Short Doyle / Medi-Cal Claims Processing System

Health Insurance Portability and Accountability Act (HIPAA)

Trading Partner Companion Guide

for the

837 Professional and Institutional Health Care Claims and the 835 Payment Advice

Version 2.0
June 2007

DOCUMENT CONTROL SHEET

Approvals

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June 2007	Vonnie Ryser	On File
June 2007	Gary Renslo	On File

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1	Department of Mental Health	Website: http://www.dmh.ca.gov/hipaa
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DMH Contact Information

- Translator: HIPAA-TCS@dmh.ca.gov
- ITWS: Take the ITWS Virtual Tour for basic information related to ITWS enrollment and uploading claim files. For further information, please call ITWS Administration at (916) 654-3117.

Useful Links

The 837 Professional and (837P) and 837 Institutional (837I) Implementation Guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at http://www.wpc-edi.com. Other important websites:

- Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
- United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/
- Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
- Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
- National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
- National Uniform Billing Committee (NUBC) – http://www.nubc.org/
- Accredited Standards Committee (ASC X12) – http://www.x12.org/

1 INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with electronic data interchange (EDI) standards for health care established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings brought about by EDI, transactions and code set standards have been developed to be implemented consistently by all organizations involved in EDI. By July 1, 2007, all trading partners (Counties and their vendors) must submit electronic health care data to the California State Department of Mental Health (DMH) in mandated HIPAA format.

The standardized data requirements (transactions requirements and code sets) to be implemented for all health care claim electronic submissions are detailed in the ANSI X12N 837 Health Care Claims Transaction Implementation Guides (hereafter, "Implementation Guides"). An addendum has been published for each of the nine Implementation Guides; the addenda must also be used to properly implement EDI transactions.

1.1 PURPOSE OF THE COMPANION GUIDE

The purpose of this Companion Guide is to document any assumptions, conventions, or data issues that may be specific to DMH business processes when implementing the HIPAA ASC X12N Implementation Guides. This Companion Guide does NOT replace the Implementation Guides, nor does it attempt to amend any of the rules therein or impose any mandates on DMH trading partners. Readers of this Companion Guide should be acquainted with the Implementation Guides, their structure and content. Information contained in the HIPAA Implementation Guides has not been repeated here, although the Guides have been referenced when necessary.

The Companion Guide provides information necessary for trading partners to submit claims/encounters electronically to DMH for adjudication and processing through the Short-Doyle Medi-Cal (SD/MC) system. Included are data elements that are either required, or required in certain circumstances, to meet HIPAA validation and SD/MC processing requirements.

Note that certain information is not within the scope of this document, specifically:

- Information related to claim transactions for the purpose of Coordination of Benefits (COB).
- Information about how DMH adjudicates specific claims.
- Privacy and security protection regarding the use of the system or application technology to send and receive a transaction set. For example, registration and management of users, assignment and exchange of passwords, user IDs, digital certificates, authentication, authorization, and other access restrictions are not addressed in detail in this Companion Guide. This document assumes that the transaction exchange will take place in a processing and communication environment that is secure at both ends for the senders and the receivers of data.

1.2 REQUIREMENTS FOR SUBMITTING CLAIM FILES

Electronic data files must be submitted to DMH according to specific requirements, including file type, size, and segregated functional group; data delimiters; and information specific to the claim.

1.3 FILE TYPES

Some electronic files are created and generated by, or on behalf of, a County for submitting claims or other information to DMH. Other files are created by DMH either in response to a request received from a County or as a means to provide pertinent information to Counties. The following table identifies each inbound and outbound file type that DMH recognizes for SD/MC claims processing.

Table 1: Inbound and Outbound Files

INBOUND (SUBMISSIONS TO DMH)	OUTBOUND (RESPONSES TO COUNTIES)
• 837 Professional Health Care Claim - ASC X12N 837 (004010X098A1) X • 837 Institutional Health Care Claim - ASC X12N 837 (004010X096A1) X	• 997 Functional Acknowledgement • TA1 Interchange Acknowledgement • 835 Health Care Claim Payment Advice - ASC X12N 835 (004010X091A1) X

1.4 DATA DELIMITERS

A data delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105-byte, fixed-length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange control header, delimiters are not to be used in a data element value elsewhere in the transaction.

Table 2: Default Data Delimiters

DESCRIPTION	DEFAULT DELIMITER
Data Element Separator	* Asterisk
Sub-element Separator	: Colon
Segment Terminator	~ Tilde

2 HIPAA TESTING AND CERTIFICATION

DMH has established a testing procedure that ensures that 837 claim files submitted by the Counties via the Information Technology Web Services (ITWS) portal will pass HIPAA translator[1] and SD/MC edits, be processed successfully (adjudicated) by the SD/MC system, and result in creation of the 835 Health Care Claim Payment/Advice (835). A County successfully completing testing is then certified (approved) for submitting claims in Production. There are four major goals for the testing/certification process:

- Each submitted file passes Claredi[2] edits, successfully generating a positive 997 acknowledgement.
- The file passes translator edits (if not, all errors must be corrected and the file is resubmitted.)
- The file passes SD/MC claim adjudication edits.
- The corresponding 835 output for each file is reviewed and accepted by the County and DMH.

2.1 LEVEL 5 HIPAA COMPLIANCE

The DMH testing procedure has been designed to achieve "level 5 HIPAA compliance." This term refers not to sequential levels but to types of testing developed by the Workgroup for Electronic Data Interchange/Strategic National Implementation Process (WEDI/SNIP). DMH has incorporated the five validation types described below into the testing process to ensure comprehensive quality assurance (QA) process for HIPAA compliance.

Table 3: WEDI/SNIP Validation Types for HIPAA Compliance

Type 1	EDI syntax integrity testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or National Council for Prescription Drug Programs (NCPDP) syntax, and compliance with X12 and NCPDP rules.
Type 2	HIPAA syntactical requirement testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included is testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.
Type 3	Balancing – Testing the transaction for balanced field totals, financial balancing of claims or remittance advice, and balancing of summary fields, e.g. all claim line item amounts equal the total claim amount (see pages 19-22, 835 Healthcare Claim Payment/Advice Implementation Guide).

1 The translator converts HIPAA-standard EDI file formats such as the 837 into nonstandard transaction formats such as those required for the legacy SD/MC system.

2 Claredi is HIPAA EDI transaction compliance certification software.

Type 4	Situation testing of specific inter-segment situations described in the HIPAA Implementation Guides, such that: If A occurs then B must be populated. This includes the validation of situational fields given values or situations present elsewhere in the file. Example: if the claim is for an accident, the accident date must be present.
Type 5	External code set testing for valid Implementation Guide-specific code set values and other code sets adopted as HIPAA standards. This validates the code sets and ensures the usage is appropriate for a particular transaction and the coding guidelines that apply to the specific code set. Validates external code sets and tables, status codes, and adjustment reason codes and their appropriate use for the transaction.

2.2 HIPAA TESTING/CERTIFICATION PROCEDURE

This section provides information related to HIPAA certification. The table below summarizes the documentation requirements to begin the certification process.

Table 4: Documentation Required Prior to Testing

DOCUMENTATION REQUIRED BY DMH	ENTITY REQUIRED TO SUBMIT DOCUMENTATION
Trading Partner Agreement	Counties Billing Directly
ITWS Enrollment Request Form	Counties Billing Directly Vendors Billing on Behalf of Counties

Upon approval of these documents, DMH will notify the submitter that they are approved to send test transactions as indicated on the Trading Partner Agreement.

Follow the testing/certification steps in the table below. If you have questions, please contact HIPAA-TCS@dmh.ca.gov.

Table 5: HIPAA Testing/Certification Steps

Step 1	**Submit Trading Partner Agreement to DMH.** The template is available from the DMH website at: http://www.dmh.ca.gov/hipaa/tcs.asp
Step 2	**Obtain access to ITWS.** If you do not have an ITWS user ID yet, you will need to go through the new user enrollment process. See the Pre-Enrollment Guide available on the ITWS website at https://mhhitws.cahwnet.gov/. If you are an existing ITWS user but do not have access to the SD/MC-DMH system, you will need to request an additional membership. Access to ITWS will not be available until you have received authorization via email (allow 3–5 working days). Questions regarding user access may be directed to the ITWS Helpdesk at https://mhhitws.cahwnet.gov/docs/public/contact.asp.
Step 3	**Create an 837P test file (and, if applicable, an 837I test file**). The County must begin testing by submitting a HIPAA test file similar in the number of claims and total dollar amount to their average production claim file. The translator certification requirement is that at least 80% of the claim file total billed amount is successfully validated and translated. A minimum of three successful test files will be required. Meeting this requirement is a two-step process: 1. The first step confirms that the claim submitted is in HIPAA-compliant format and has been successfully translated from HIPAA format to proprietary format. 2. After passing step one, the test claim file will be submitted to the SD/MC system for processing, and the resulting Explanation of Balances (EOB) and 835 will be returned to ITWS.
Step 4	**Zip and name your test file.** Each claim file must be compressed and encrypted using PKZip® version 6.0.147 or WinZip® version 8.0 (or later). The password for zipping the file is the same as the one used currently in the production environment. Each zipped file may contain only one test claim file. • The test file must be named according to the following format: DMH_SDM_CC_T_837_YYYYMM_##.TXT • The test file must be named according to the following format: DMH_SDM_CC_T_837_YYYYMM_##.ZIP --- CC: County Code T: Test file YYYYMM: Year and Month ##: Sequential Number for same month of service, “01-99”

Step 5	**Upload test data to ITWS.** Log into ITWS. From the Systems menu, select the Short-Doyle/Medi-Cal Claims - EOB (HIPAA Testing) system. (See the ITWS Virtual Tour for upload instructions.)
Step 6	**Pass HIPAA validation (Claredi) edits**. All test files must meet Workgroup for Electronic Data Interchange / Strategic National Implementation Process (WEDI/SNIP) Types 1–5 testing requirements. When an 837 file is successfully uploaded via ITWS, HIPAA validation using Claredi is performed. The 997 Functional Acknowledgement provides file status. The County receives an email message when the 997 is available. Errors must be corrected; the test file is then resubmitted using the ITWS Processing Status screen, which provides error description details (click on the HIPAA Error Details button).
Step 7	**Pass translator validation edits.** The 837 file must pass translator edits before the SD/MC file for adjudication is created. All translator errors must be corrected before the file is resubmitted via the ITWS Processing Status screen. The SD/MC file is then created, a batch number is assigned, and the file is sent to SD/MC for processing. The submitting County will receive an email notice when the claim file has been successfully validated by the translator.
Step 8	**Pass SD/MC adjudication edits and generate the 835 Health Care Claim Payment/Advice.**
Step 9	**Review the Explanation of Balances (EOB) and the 835 Health Care Claim Payment/Advice.**
Step 10	**Confirm test results.** The County sends an email confirmation of acceptance of test results to HIPAA-TCS@dmh.ca.gov. The acceptance must be sent by County staff rather than a vendor.
Step 11	**County receives certification via a production-readiness letter**. When testing has been successfully completed, DMH confirms certification with a letter to the County. The County may then begin submitting claims to production.

3 837 HEALTH CARE CLAIM FILES

This section includes requirements that apply to 837P and 837I claims.

3.1 ENVELOPE REQUIREMENTS

The Interchange Control structure (the ISA/IEA "envelope" necessary for electronic submission) must be only one type of Functional Group, either Professional or Institutional. 837P and 837I transactions must be submitted in separate files. The ISA/IEA envelope is evaluated immediately upon submission and the entire file is either accepted or rejected.

3.2 CLAIM AND SERVICE LOOP LIMITATIONS

The 837 Professional Health Care Claim (837P) and 837 Institutional Health Care Claim (837I) transactions are designed to transmit one or more claims for each provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is limited as follows.

- The Claim Information loop (2300) is limited to 100 claims per patient
- The Service Line loop (2400) is limited to 50 service lines per 837P claim
- The Service Line loop (2400) is limited to **one** service line per 837I claim

3.3 CHARACTER CASE REQUIREMENTS

- Lower-case characters on inbound transactions are not converted to uppercase except for the Service Line Unique Identifier.
- Fields used to match with the California Department of Health Services' Medi-Cal Eligibility Database Systems (MEDS) must be submitted in uppercase.

3.4 DECIMAL FORMAT REQUIREMENTS

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions.

- The decimal data element type is represented as "R."
- The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. The length of a decimal type data element does not include the decimal point.
- Negative values are not allowed. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.
- Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement.
- Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision.
- The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited.

3.5 GENERAL REQUIREMENTS

- If any part of a transaction is not compliant through Level 5, the entire file is rejected.
- Fields containing data elements required by the Implementation Guides but not used by SD/MC claiming system must be completed with a valid value to avoid compliance errors.

3.6 USE OF A SERVICE LINE UNIQUE IDENTIFIER (UNIQUE ID)

A Unique ID is required for each service line. Identification of each service line is achieved differently for 837P and 837I claims: the 837P uses the Line Item Control Number (loop 2400); the 837I uses the Patient Account Number in loop 2300. An 837I must have only ONE service line per CLM loop.

Unique IDs may consist of any combination of upper and lower case characters. The system converts all characters to upper case for purposes of matching and duplicate edits. The SD/MC system supports identifiers up to 23 bytes and requires the first 5 characters to be numeric and unique for each provider (Service Facility Location) for each weekly cycle of the SD/MC claim system. The remaining characters must be alphanumeric or any of the American Standard Code for Information Interchange (ASCII) characters in the following table.

Table 6: Allowable Unique ID ASCII Characters

CHARACTER	DESCRIPTION
SP	Space
!	Exclamation mark
"	Quotation mark
#	Cross hatch (number sign)
$	Dollar sign
%	Percent sign
&	Ampersand
`	Closing single quote (apostrophe)
(	Opening parentheses
)	Closing parentheses
+	Plus
,	Comma
-	Hyphen, dash, minus
.	Period
/	Slash (forward or divide)
0	Zero
1	One
2	Two
3	Three
4	Four
5	Five
6	Six
7	Seven
8	Eight
9	Nine

CHARACTER	DESCRIPTION
;	Semicolon
<	Less than sign (< in HTML)
=	Equals sign
>	Greater than sign (> in HTML)
?	Question mark
@	At-sign
A	Upper case A
B	Upper case B
C	Upper case C
D	Upper case D
E	Upper case E
F	Upper case F
G	Upper case G
H	Upper case H
I	Upper case I
J	Upper case J
K	Upper case K
L	Upper case L
M	Upper case M
N	Upper case N
O	Upper case O
P	Upper case P
Q	Upper case Q
R	Upper case R
S	Upper case S
T	Upper case T
U	Upper case U
V	Upper case V
W	Upper case W
X	Upper case X
Y	Upper case Y
Z	Upper case Z
[	Opening square bracket
\	Backslash (Reverse slant)
]	Closing square bracket
_	Underscore
`	Opening single quote
a	Lower case a
b	Lower case b
c	Lower case c
d	Lower case d
e	Lower case e
f	Lower case f
g	Lower case g

CHARACTER	DESCRIPTION
h	Lower case h
i	Lower case i
j	Lower case j
k	Lower case k
l	Lower case l
m	Lower case m
n	Lower case n
o	Lower case o
p	Lower case p
q	Lower case q
r	Lower case r
s	Lower case s
t	Lower case t
u	Lower case u
v	Lower case v
w	Lower case w
x	Lower case x
y	Lower case y
z	Lower case z
{	Opening curly brace
|	Vertical line
}	Closing curly brace

3.7 USING THE NATIONAL PROVIDER IDENTIFIER (NPI)

Prior to implementation of the HIPAA-mandated NPI, DMH and the Counties have used a four-digit code to identify service providers on SD/MC claims. This code identifies either a particular provider's service facility location (SFL) or one of the following provider categories:

1. Fee for Service (FFS) Providers:
    a. Psychiatrists
    b. Psychologists
    c. Registered Nurses
    d. Marriage and family Therapists
    e. Licensed Clinical Social Workers
    f. Multi-Specialty (Mixed) Groups
2. Administrative Services Organization Foster Care (ASO-FC) Providers
3. Healthy Families Program Inpatient (HFP-IP) Providers

Counties must use the NPI to identify Service Facility Location (SFL) and Rendering Provider on 837P and 837I electronic claim transactions. NPIs must also be used to identify the Billing Provider and the Pay-To Provider when the Federal Tax ID is not the primary identifier.

The DMH translator will crosswalk the SFL NPI to the four-digit Provider Number that the SD/MC claims system currently recognizes. For DMH to establish the crosswalk, a County must report the Service Facility Location NPI(s) for each of its SD/MC provider numbers (including

satellites) to the DMH Statistics and Data Analysis (SDA) Unit via a spreadsheet supplied by SDA or a similar County-created document.

DMH has also developed alternate crosswalks for FFS, ASO-FC and HFP-IP providers to temporarily assist Counties that may have difficulty collecting and reporting these NPIs to SDA. The alternate crosswalk for FFS providers uses the note segment in conjunction with the taxonomy code. The alternate crosswalks for the ASO-FC and HFP-IP providers use only the note segment. If the SFL NPI crosswalk fails for an FFS, ASO-FC, or HFP-IP provider, the Translator will perform an alternate crosswalk provided that the necessary information is on the claim.

3.7.1 Phased NPI Implementation

The DMH translator can process a County's claims in one of three modes depending on the County's individual NPI readiness:

1. In the Standard Mode the Translator uses only the SD/MC Provider Number. NPIs (if any) are ignored.
2. In the Dual Use Mode the Translator uses the SFL NPI and/or the SD/MC Provider Number (depending on what was submitted on the claim) as follows:
   a) If only the SD/MC Provider Number is provided, the Translator uses that number and issues a warning message to the County that the NPI was not provided.
   b) If both the SFL NPI and the SD/MC Provider number are on the claim, the Translator first attempts to crosswalk the SFL NPI. If the SFL NPI crosswalk fails then the Translator performs an alternate crosswalk if the provider is FFS, ASO-FC, or HFP-IP. If the crosswalk does not return an SD/MC Provider Number that matches the SD/MC Provider Number submitted on the claim, then the Translator issues a warning message to the County and uses the SD/MC Provider Number submitted on the claim.
   c) If only the SFL NPI is provided, the Translator first attempts to crosswalk the SFL NPI. If the SFL NPI crosswalk fails then the Translator performs an alternate crosswalk if the provider is FFS, ASO-FC, or HFP-IP. If the crosswalk does not return a unique SD/MC Provider Number then the Translator rejects the 837.
3. In the NPI Mode each claim must have an SFL NPI and must not have an SD/MC Provider Number. The Translator performs the NPI crosswalk. If the crosswalk fails, then the Translator performs an alternate crosswalk if the provider is FFS, ASO-FC, or HFP-IP. If the crosswalk fails to return a unique SD/MC Provider Number, then the Translator rejects the 837 file.

Table 7: DMH HIPAA NPI Remediation
Claim Encoding Rules and Translator Behavior by Processing Mode

Processing Mode	How Counties Must Encode Their Claims				DMH Translator Behavior Based on the Provider Identifier(s) Found on the Claim		
	SD/MC Provider #	NPI	FFS, ASO-FC and HFP-IP Identifiers	Taxonomy Code	SD/MC Provider # Only	SD/MC Provider # and NPI	NPI Only
Standard	Required	Optional	Not Applicable		Use SD/MC #.	1. Use the SD/MC #. 2. Ignore the NPI.	Reject the 837.
Dual Use	Situational	Situational	Needed for the alternate crosswalks.	Needed for the alternate FFS crosswalk.	1. Use the SD/MC #. 2. Issue a warning to the County that the NPI was not provided.	1. Crosswalk the NPI. 2. If the NPI crosswalk fails then crosswalk for FFS, ASO or HFP-IP if applicable. 3. If the crosswalk fails to return an SD/MC # that matches the submitted SD/MC # then issue County warning. 4. Use the submitted SD/MC #.	1. If the NPI crosswalk fails then crosswalk for FFS, ASO or HFP-IP, if applicable. 2. If the crosswalk fails to return a unique SD/MC # then reject the 837.
NPI	Not Allowed	Required	Needed for the alternate crosswalks.	Needed for the alternate FFS crosswalk.	Reject the 837.	Reject the 837.	1. Crosswalk the NPI. 2. If the NPI crosswalk fails then crosswalk for FFS, ASO or HFP-IP if possible. 3. If the crosswalk fails to return a unique SD/MC # then reject the 837.

3.7.2 Information Used by the Crosswalks

The crosswalks compare information on the claim with information from the DMH Online Provider System (OPS) to determine the SD/MC provider number to send to the SD/MC claims system.

Table 8: Information Used by the Provider Crosswalks

TYPE OF CROSSWALK	INFORMATION ON 837P/I CLAIM	COMPARED TO THE DMH OPS DATA
NPI	**837P or 837I**. • County Code • SFL NPI • Date of Service	• County Code • NPI • Provider Begin Date • Provider End Date
FFS	**837P only.** • County Code • FFS Indicator o "ADD" found in Claim Note Reference Code (loop 2300, element NTE01) o "FFS" found in claim Note Text (loop 2300, element NTE02) • Rendering Provider Taxonomy Code (loop 2310B, element PRV03) • Date of Service	• County Code • Taxonomy Code • Provider Begin Date • Provider End Date
ASO-FC	**837P only.** • County Code • ASO-FC Indicator o "ADD" found in Claim Note Reference Code (loop 2300, element NTE01) o "ASO-FC" found in Claim Note Text (loop 2300, element NTE02) • Date of Service	• County Code • Provider Begin Date • Provider End Date
HFP-IP	**837I only**. • County Code • HFP-IP Indicator o "UPI" found in Claim Note Reference Code (loop 2300, element NTE01) o "HFP-IP" found in Claim Note Text (loop 2300, element NTE02) • Date of Service	• County Code • Provider Begin Date • Provider End Date

3.7.3 Submitting Claim Files to Test and Production Environments

By default, all Counties' files in the Production Environment are processed in the Standard Mode. In order for a County's claims in the Production Environment to be processed in Dual Use Mode or NPI Mode the County must submit an 837 claim file to the DMH Test Environment. Only after the contents of the file have been tested and verified will DMH allow the County's claims in the Production Environment to be processed in the new mode.

A starting date will be associated with each processing mode that a County uses. When DMH receives an 837 file the Translator will use the file's submission date to determine which mode's rules to use when processing the claims. For this reason a County's processing mode starting dates cannot overlap and only one processing mode can be in effect on any given day.

A County may elect to use the NPI Mode without first using the Dual Use Mode. However, DMH recommends that Counties begin in Dual Use Mode because it lowers the risk of having the 837 claim file rejected. Follow the NPI testing/certification steps in the table below. If you have questions, please contact HIPAA-TCS@dmh.ca.gov.

Table 9: NPI Testing/Certification Steps

Step 1	**Submit NPIs to the DMH Statistics and Data Analysis Unit (SDA)** SDA has provided each County with a spreadsheet of the SD/MC Provider Numbers for which the County must submit an NPI. Fill out the spreadsheet and email it to Carla.Minor@dmh.ca.gov. Contact the Helpdesk at (916) 654-3117 with any questions about this step.
Step 2	**Use the Online Provider System (OPS) to verify that the NPIs have been associated with the SD/MC Provider Numbers.**
Step 3	**Request a new NPI processing mode.** Send an email to HIPAA-TCS@dmh.ca.gov specifying the NPI processing mode (Dual-Use or NPI).
Step 4	**Create an 837P test file and, if applicable, an 837I test file**.
Step 5	**Zip and name your test file.** Each claim file must be compressed and encrypted using PKZip® version 6.0.147 or WinZip® version 8.0 (or later). The password for zipping the file is the same as the one used currently in the production environment. Each zipped file may contain only one test claim file. • The test file must be named according to the following format: DMH_SDM_CC_T_837_YYYYMM_##.TXT • The test file must be named according to the following format: DMH_SDM_CC_T_837_YYYYMM_##.ZIP --- CC: County Code T: Test file YYYYMM: Year and Month ##: Sequential Number for same month of service, "01-99"

Step 6	**Upload test data to ITWS.** Log into ITWS. From the Systems menu, select the Short-Doyle/Medi-Cal Claims - EOB (HIPAA Testing) system. (See the ITWS Virtual Tour for upload instructions.)
Step 7	**Pass HIPAA validation (Claredi) edits**. All test files must meet Workgroup for Electronic Data Interchange / Strategic National Implementation Process (WEDI/SNIP) Types 1–5 testing requirements. When an 837 file is successfully uploaded via ITWS, HIPAA validation using Claredi is performed. The 997 Functional Acknowledgement provides file status. The County receives an email message when the 997 is available. Errors must be corrected; the test file is then resubmitted using the ITWS Processing Status screen, which provides error description details (click on the HIPAA Error Details button).
Step 8	**Pass translator validation edits.** The 837 file must pass translator edits before the SD/MC file for adjudication is created. All translator errors must be corrected before the file is resubmitted via the ITWS Processing Status screen. The SD/MC file is then created, a batch number is assigned, and the file is sent to SD/MC for processing. The submitting County will receive an email notice when the claim file has been successfully validated by the translator.
Step 9	**Pass SD/MC adjudication edits and generate the 835.**
Step 10	**Review the Explanation of Balances (EOB) and the 835.**
Step 11	**Confirm test results.** The County sends an email confirmation of acceptance of test results to HIPAA-TCS@dmh.ca.gov. The acceptance must be sent by County staff rather than a vendor.
Step 12	**County receives an NPI Crosswalk certification email**. After DMH approves the County's test results, DMH will send a confirmation email that the County is certified for the particular Translator Processing Mode. The County is now ready to have its claims processed by the Translator according to the rules of that mode.

3.7.4 NPI Scenarios

This section contains examples of how to populate the provider information on an 837 for different types of providers and billing scenarios. The loops listed below are for illustrative purposes and do not contain all of the data elements required for billing.

Table 10: NPI Scenarios

PROVIDER TYPE	SCENARIO	SEE EXAMPLE #
County-Owned Provider	Facility location at County Mental Health administrative address.	1A, 1B
	The provider is a satellite and the parent is the County provider at the administrative address.	2
	The provider is NOT located at the administrative office.	3A, 3B
	The provider is a satellite and the parent is the County provider NOT at the administrative address.	4
Contract Provider	The provider is a parent.	5A, 5B
	The provider is a satellite.	6
FFS Provider Legal Entity begins with "00F" followed by County code: 00F##.	The provider is a group practice.	7
	The provider is an individual practice (including sole proprietor or sole proprietorship).	8
ASO-FC Provider Legal Entity begins with "AFC" followed by County code: AFC##	The provider is a group practice.	9
	The provider is an individual practice (including sole proprietor or sole proprietorship).	10
HFP-IP Provider Legal Entity begins with "HFP" followed by County code: HFP ##	The provider is a hospital (837I only).	11

Example #1: County-owned provider, where the service location is at the County Mental Health administrative address and the provider is a parent provider.

Example 1A: Institutional Claims (Hospital Inpatient Claims)

837I (Institutional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification Code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	This is the County Mental Health (MH) department NPI where the hospital is located at the same address as the MH administrative office. This NPI is used to crosswalk to the SD/MC provider number.
	REF01	Billing Provider Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Billing Provider Additional Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310A		Attending Provider Name		Claim Level
	NM108	Identification Code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	
2420A		Attending Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	

Example 1B: Professional Claims (Non-hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing Provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	This is the County MH NPI where the clinic is located at the same address as the MH administrative office. This NPI will be used to crosswalk to the SD/MC provider number.
	REF01	Billing Provider Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Billing Provider Additional Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #2: County-owned provider. Parent provider is located at the County Mental Health administrative address and the service location is a satellite site.

Example 2: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the satellite NPI. It will be cross walked to the parent SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the parent provider number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #3: County-owned provider, where the service location is **not** at the County mental health administrative address and the provider is a parent provider.

Example 3A: Institutional Claims (Hospital Inpatient Claims)

837I (Institutional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310E		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the provider NPI and will be used to crosswalk to the SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310A		Attending Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	
2420A		Attending Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	

Example 3B: Professional Claims (non-hospital inpatient claims)
837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the provider NPI. It will be cross walked to the SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #4: County-owned provider, where the parent provider is **not** located at the County mental health administrative address and the service location is a satellite site.

Example 4: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the satellite NPI. It will be cross walked to the parent SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #5: County-contracted providers except FFS, ASO-FC, and HFP-IP providers.

Example 5A: Institutional Claims (Hospital Inpatient Claims)
837I (Institutional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310E		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This provider NPI will be used to crosswalk to the SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310A		Attending Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	
2420A		Attending Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	

Example 5B: Professional Claims (Non-Hospital Inpatient Claims)
837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing Provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the provider NPI. It will be cross walked to the SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply this number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #6: County-contracted provider where service location is a satellite site.

Example 6: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM109	Billing Provider Identifier	County MH NPI	
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the satellite NPI. It will be cross walked to the parent SD/MC provider number.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the parent provider number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #7: FFS contract provider where the provider is a group practice.

Example 7: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2300		Claim Information		
	NTE01	Note reference Code	ADD	Indicates that a value is in NTE02.
	NTE02	Claim Note Text	FFS	Identifies the provider as a FFS provider.
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	FFS NPI	Use the FFS group practice NPI. Enter the individual service provider's NPI in loop 2420A, element NM109.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider #	Supply the County's SD/MC FFS provider number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the FFS Group Practice.
	PRV02	Reference Identification Qualifier	ZZ	Indicates a taxonomy code is in PRV03.

Example 7: Professional Claims (Non-Hospital Inpatient Claims), continued

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	
	PRV03	Provider Taxonomy Code	Provide the taxonomy code of the group practice. 2084P0800X Psychiatry (psychiatrist) 103T00000X Psychologist 163W00000X Registered Nurse 106H00000X Marriage & Family Therapist 1041C0700X Social Worker – Clinical (LCSW) 193200000X Group – Multi-Specialty (Mixed)	
LOOP	**DATA ELEMENT**	**INDUSTRY NAME**	**CONTENTS OF DATA ELEMENT**	**COMMENTS**
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #8: FFS contract provider where the provider is an individual (sole proprietor or sole proprietorship).

Example 8: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2300		Claim Information		
	NTE01	Note reference Code	ADD	
	NTE02	Claim Note Text	FFS	Identifies the provider as a FFS provider.
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	FFS NPI	This is the FFS Sole Proprietor / Proprietorship NPI.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the County's SD/MC FFS provider number only in Standard Mode or Dual-Use Mode.

Example 8: Professional Claims (Non-Hospital Inpatient Claims), continued

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the sole proprietor providing the service.
	PRV02	Reference Identification Qualifier	ZZ	Indicates a taxonomy code is provided (PRV03).
	PRV03	Provider Taxonomy Code	2084P0800X 103T00000X 163W00000X 106H00000X 1041C0700X	Sole Proprietor's Taxonomy Code: Psychiatry (psychiatrist) Psychologist Registered Nurse Marriage & Family Therapist Social Worker – Clinical (LCSW)

Example #9: ASO-FC contract provider where the provider is a group practice.

Example 9: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2300		Claim Information		
	NTE01	Note reference Code	"ADD"	
	NTE02	Claim Note Text	"ASO-FC"	Identifies the provider as an ASO-FC provider.
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI of the group practice contracting with the ASO	This is the group practice NPI.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the County's SD/MC ASO-FC provider number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.
2420A		Rendering Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example #10: ASO-FC contract provider where the provider is an individual (sole proprietor or sole proprietorship).

Example 10: Professional Claims (Non-Hospital Inpatient Claims)

837P (Professional Health Care Claim, 4010A1)

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2300		Claim Information		
	NTE01	Note reference Code	"ADD"	
	NTE02	Claim Note Text	"ASO-FC"	Identifies the provider as an ASO-FC provider.
2310D		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the individual's NPI.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the County's SD/MC ASO-FC provider number only in Standard Mode or Dual-Use Mode.
2310B		Rendering Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Rendering Provider Primary Identifier	NPI	NPI of the clinician or person providing the service.

Example 11: HFP-IP Inpatient Institutional Claims (IPC) (Hospital Inpatient Claims) 837I (Institutional Health Care Claim, 4010A1).

LOOP	DATA ELEMENT	INDUSTRY NAME	CONTENTS OF DATA ELEMENT	COMMENTS
1000A		Submitter Name		
	NM108	Identification code Qualifier	46	Electronic Transmitter Identification Number (ETIN).
	NM109	Submitter Identifier	Numeric County Code	Refer to Table O, County Codes.
2010AA		Billing provider Name		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Billing Provider Identifier	County MH NPI	
2300		Claim Information		
	NTE01	Note reference Code	"UPI"	
	NTE02	Claim Note Text	"HFP-IP"	Identifies the provider as an HFP-IP provider.
2310E		Service Facility Location		
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Facility Primary Identifier	NPI	This is the NPI of the IPC facility.
	REF01	Service Facility Location Reference ID Qualifier	1D	Indicates that REF02 contains a Medicaid provider number.
	REF02	Facility Secondary Identifier	SD/MC Provider Number	Supply the County's SD/MC HFP-IP provider number only in Standard Mode or Dual-Use Mode.
2310A		Attending Provider Name		Claim Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	
2420A		Attending Provider Name		Service Level
	NM108	Identification code Qualifier	XX	Indicates an NPI is provided (NM109).
	NM109	Attending Provider Primary Identifier	NPI	

3.8 REPORTING OTHER PAYER AND PATIENT RESPONSIBILITY/PAID AMOUNTS

As Medi-Cal is the "payer of last resort," the Counties must first submit claims to other payers when the beneficiary has third party coverage. This means when a bill is submitted to Medi-Cal for payment, all third party payers should have either paid or denied the claim.

HIPAA TCS regulations require the inbound 837 transaction to report the gross (non-adjusted) amounts of all "usual and customary charges" in the "Line Item Charge Amount" data element. The system will calculate the necessary adjustments from the 837 to include payments from Medicare, other health coverage, and patient fees.

The system will not clear the "Share of Cost" status on the Medi-Cal Eligibility file. Counties should continue using their current process to clear "Share of Cost."

3.9 POPULATING THE CLAIM LEVEL AND SERVICE LEVEL AMOUNT FIELDS

3.9.1 Claim Level

The AMT segments must be populated at the claim level for use with the crossover indicator. Amounts reported at the claim level must be the sum of the related amounts reported at the service level. Only CAS adjustments reported at the service level will be used to calculate the Net Billed Amount.

3.9.2 Service Level

The AMT segments must be populated at the service level. Counties must use the SVD and CAS segments at the service (not claim) level.

All calculations of SD/MC billed amounts will be accomplished in the 2400 Service Level Loop. If the patient has multiple health coverages, there must be multiple 2430 Line Adjudication Loops. To properly build the 2400 Service Level Loop:

1. The SV1-02, Line Item Charge Amount must contain the gross (non-adjusted) amount of all "usual and customary charges" that apply to the service.
2. The SVD-02, Service Line Paid Amount must contain payments from Medicare or any other health coverage for the service.
3. The CAS*PR, Patient Responsibility Line Adjustment must contain any patient responsibility amount for the service. The patient responsibility/patient paid amount should be also reported in the AMT02, Patient Paid Amount; however, this element is not used in the net billed amount calculation. The CAS*PR element will be rolled into the unknown/other adjustment (CAS*OA) element on the 835.

The following example shows how the DMH translator will calculate the net billed amount for the SD/MC proprietary file.

Other Subscriber Information (2320)
SBR*P*18***IP****MB~
AMT*D*15~
AMT*B6*15~
DMG*D8*19480107*U~
OI***Y*B**Y~
Other Subscriber Name (2330A)
NM1*IL*1*DOE*JOHN****MI*98765~
N4*RED BLUFF*CA*96080~
Other Payer Name (2330B)
NM1*PR*2*INSURANCE*****PI*951234567~
Other Subscriber Information (2320)
SBR*S*18***MB****MB~
AMT*D*25~
AMT*B6*25~
AMT*F2*5.25~
DMG*D8*19480107*U~
OI***Y*B**Y~
Other Subscriber Name (2330A)
NM1*IL*1*DOE*JOHN****MI*999999999A~
N4*RED BLUFF*CA*96080~
Other Payer Name (2330B)
NM1*PR*2*MEDICARE*****PI*31140~
Service Line (2400)
LX*1~
SV1*HC:H2015:HE*118.8*UN*4***1~
DTP*472*D8*20050701~
REF*6R*89055~
Line Adjudication Information (2430)
SVD*951234567*15*HC:H2015**1~
CAS*PR*2*5.25~
DTP*573*D8*20050805~
Line Adjudication Information (2430)
SVD*31140*25*HC:H2015**1~
CAS*CO*172*73.55~
DTP*573*D8*20050810~

Line Item Charge Amount 118.8
Service Line Paid Amount - 15
Patient Responsibility - 5.25
Service Line Paid Amount - 25

SD/MC Net Billed Amount 73.55

The “Line Item Charge Amount” field on the 837 (Loop 2400, SV1-02) may not match the “Line Item Charge Amount” field on the 835 (Loop 2110, SVC-02) because the gross amount coming in on the 837 is adjusted to create the Net Billed Amount in the SD/MC system, which is reported in the “Line Item Charge Amount” field on the 835.

3.10 HIPAA VALIDATION CHECK (CLAREDI)

Claredi will produce the following error message when the 2430/SVD02 data element minus the 2430/CAS03 data element do NOT equal the 2400/SV102 data element: "The Service Line Paid amounts (2430/SVD-02) and all Service Line Adjustment amounts (2430/CAS) do not equal the 'Line Item Charge' for this Service Line (Loop 2400)."

Claredi searches the 837 transaction for two cases (methods) of claiming. These two cases are the normal case and the unbundled case. The total of the payment amount in SVD02 plus all of the adjustments in the CAS segment(s) must equal the "Line Item Charge Amount" in SV102. There can be up to 6 adjustments in a CAS segment, and many CAS segments. Claredi totals all of them.

In the unbundled case, Claredi checks for multiple 2430 loops, starting with SVD segments, where the Payer ID in SVD01 is the same. If 2 or more SVDs in the same 2400 loop contain the same Payer ID, we consider it an unbundled charge, and therefore total all of the SVD02's minus all of the CAS segments where the SVD01 is the same Payer ID to equal the original "Line Item Charge Amount" in SV102.

3.11 837 CONTROL SEGMENTS

The following sections define the use of the control structure as it relates to communication with DMH. Rules for ensuring integrity and maintaining the efficiency of data exchange are found in Appendix A, Section A.1.1 of the X12N HIPAA Implementation Guide.

3.11.1 Segment and Data Element Description

Each segment table contains rows and columns describing different segment elements. Those components are as follows:

- Segment Name – The industry assigned segment name as identified in the Implementation Guides.
- Segment ID – The industry assigned segment ID as identified in the Implementation Guides.
- Loop ID – The loop within which the segment should appear.
- Segment Usage – Identifies the segment as required or situational.
- Segment Notes – A brief description of the purpose or use of the segment.
- Example – An example of a complete segment.
- Element ID – The industry assigned data element ID as identified in the Implementation Guides.
- Usage – Identifies the data element as R-required, S-situational, or N/A-not used based on DMH guidelines.
- Valid values – If any value exists then only that value is expected. If the value is blank then it is at the County's discretion to use an appropriate value.
- Implementation Guide Description/Valid Values – Industry name associated with the data element. If no industry name exists, this is the Implementation Guide's data element name. This column also lists in **bold** the values and/or code sets to be used.
- Comments – Description of the contents of the data elements including field lengths.

3.11.2 ISA-IEA Segments

This section describes DMH's use of the interchange control segments. It includes a description of expected sender and receiver codes and delimiters.

Segment Name		**Interchange Control Header**	
Segment ID		ISA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		All positions within each data element in the ISA segment must be filled. Delimiters are specified in the Interchange Control Header Segment. The values are as follows: * Asterisk Data Element Separator : Colon Sub element Separator ~ Tilde Segment Terminator Uppercase letters must be used in this segment.	
Example		ISA*00* *00* *ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*030918*1659*U*00401* 000000864*0*P*:~	
Element ID	Usage	Valid values	Comments
ISA01	R	00	Authorization Information Qualifier
ISA02	R	10 Blanks	Authorization Information; Fixed Length
ISA03	R	00	Security Information Qualifier
ISA04	R	10 Blanks	Security Information:
ISA05	R	ZZ	Interchange ID Qualifier
ISA06	R	For County: C + County Code + 12 Zeroes, Examples: C59000000000000	Interchange Sender ID; Valid Format (Specific values defined in Table O)
ISA07	R	ZZ	Interchange ID Qualifier
ISA08	R	INFOTECHWEBSVCS	This field must be INFOTECHWEBSVCS
ISA09	R		Interchange Date; the date format is YYMMDD. The date on which 837 is created.
ISA10	R		Interchange Time; the time format is HHMM. The time at which 837 is created.
ISA11	R	U	Interchange Control Standards Identifier
ISA12	R	00401	Interchange Control Version Number
ISA13	R		The Interchange Control Number is created by the Sender and must have the same value as in the Interchange Trailer (IEA02). It must be 9 numeric characters (e.g., 123456789).
ISA14	R	0	Acknowledgment Requested; If value were 1 = Interchange Acknowledgment (TAI01); Not currently supported 0 – No Interchange Acknowledgment Requested
ISA15	R	T or P	Usage Indicator T for Test P for Production
ISA16	R	:	Component Element Separator: The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.

Segment Name		**Interchange Control Trailer**	
Segment ID		IEA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		IEA*5*000000864~	
Element ID	Usage	Valid Values	Comments
IEA01	R		Number of included functional groups; Number of functional groups included in this interchange envelope
IEA02	R		Authorization Information same as ISA13

3.11.3 GS-GE Segments

This section describes DMH's use of the functional group control segments and the expected sender and receiver codes. There can be only one GS-GE segment in the ISA-IEA segment. The GS-GE segment may specify either 837P transactions or 837I transactions, but not both.

Segment Name		**Functional Group Header**	
Segment ID		GS	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		The functional group header used for the 837 is HC. Uppercase letters must be used in this segment.	
Example		GS*HC*C59000000000000*INFOTECHWEBSVCS*20030918*105531*5*X*004010X098A1~	
Element ID	Usage	Valid Values	Comments
GS01	R	HC	Functional Identifier Code
GS02	R	For County: C + County Code + 12 Zeroes, Example: C59000000000000	Interchange Sender ID; Valid Format (Specific values defined in Table O)
GS03	R	INFOTECHWEBSVCS	Application Receivers Code
GS04	R		Date - CCYYMMDD
GS05	R		Time - HHMMSS
GS06	R		Group Control Number must match GE02. It must be unique within ISA segment.
GS07	R	X	Responsible Agency Code
GS08	R		For 837P: 004010X098A1 For 837I: 004010X096A1

Segment Name		**Functional Group Trailer**	
Segment ID		GE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		GE*5*5~	
Element ID	Usage	Valid Values	Comments
GE01	R		Number of Transaction Sets included
GE02	R		Group Control Number same as GS06

3.11.4 Sample Interchange Control Segment

ISA*00* *00*
*ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*030918*1659*U*00401*000000864*1*
P*:
GS*HC*C59000000000000*INFOTECHWEBSVCS*20030921*1659*863*X*004010X098A1
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
GE*1*863~
IEA*1*000000864~

3.12 837 PROFESSIONAL CLAIMS AND ENCOUNTERS

3.12.1 Segment Usage

The following table lists only those segments that are needed for submission of the 837P to DMH. Failure to include a required segment results in a compliance error. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Table 11: Segment Usage – 837 Professional

SEGMENT ID	LOOP ID	SEGMENT NAME	R – REQUIRED S - SITUATIONAL
ST	N/A	Transaction Set Header	R
BHT	N/A	Beginning of Hierarchical Transaction	R
REF	N/A	Transmission Type Identifier	R
NM1	1000A	Submitter Name	R
PER	1000A	Submitter EDI Contact Information	R
NM1	1000B	Receiver Name	R
HL	2000A	Billing/Pay-To Hierarchical Level	R
PRV	2000A	Billing/Pay-to Provider Specialty Information	S
NM1	2010AA	Billing Provider Name	R
N3	2010AA	Billing Provider Address	R
N4	2010AA	Billing Provider City/State/ZIP Code	R
REF	2010AA	Billing Provider Secondary Identification	S
NM1	2010AA	Pay-To Provider Name	S
N3	2010AA	Pay-To Provider Address	S
N4	2010AA	Pay-To Provider City/State/ZIP Code	S
REF	2010AB	Pay-To Provider Secondary Identification	S
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
NM1	2010BA	Subscriber Name	R

SEGMENT ID	LOOP ID	SEGMENT NAME	R – REQUIRED S - SITUATIONAL
N3	2010BA	Subscriber Address	R
N4	2010BA	Subscriber City/State/ZIP Code	R
DMG	2010BA	Subscriber Demographic Information	R
NM1	2010BB	Payer Name	R
CLM	2300	Claim Information	R
DTP	2300	Date – Admission	S
DTP	2300	Date – Discharge	S
AMT	2300	Patient Amount Paid	S
REF	2300	Medical Record Number	R
HI	2300	Health Care Diagnosis	S
NM1	2310B	Rendering Provider Name	S
PRV	2310B	Rendering Provider Specialty Information	S
NM1	2310D	Service Facility Location	S
REF	2310D	Service Facility Location Secondary ID	S
SBR	2320	Other Subscriber Information	S
CAS	2320	Claim Level Adjustments	S
AMT	2320	Payer Paid Amount	S
AMT	2320	Allowed Amount	S
DMG	2320	Subscriber Demographic Information	S
OI	2320	Other Insurance Coverage Information	S
NM1	2330A	Other Subscriber Name	S
NM1	2330B	Other Payer Name	S
DTP	2330B	Claim Adjudication Date	S
LX	2400	Service Line Number	R
SV1	2400	Professional Service	R
DTP	2400	Date – Service Date	R
REF	2400	Line Item Control Number	R
NM1	2420A	Rendering Provider Name	S
PRV	2420A	Rendering Provider Specialty Information	S
NM1	2420C	Service Facility Location	S
N3	2420C	Service Facility Location Address	S
N4	2420C	Service Facility Location City/State/ ZIP	S
REF	2420C	Service Facility Location Secondary ID	S
SVD	2430	Line Adjudication Information	S
CAS	2430	Line Adjustment	S
DTP	2430	Line Adjudication Date	S

SEGMENT ID	LOOP ID	SEGMENT NAME	R – REQUIRED S - SITUATIONAL
SE	N/A	Transaction Set Trailer	R

3.12.2 Segment and Data Element Description

Segment Name		**Transaction Set Header**	
Segment ID		ST	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment begins the transaction.	
Example		ST*837*0001~	
Element ID	Usage	Valid Values	Comments
ST01	R	837	Transaction Set Identifier Code
ST02	R		This number is assigned by the sender. ST02 must match SE02

Segment Name		**Beginning of Hierarchical Transaction**	
Segment ID		BHT	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment provides the bill date of the claim submitted.	
Example		BHT*0019*00*4144000001*20030416** CH~	
Element ID	Usage	Valid Values	Comments
BHT01	R	0019	Information Source
BHT02	R	00	Transaction Set Purpose Code 00 = original, 18 = reissue
BHT03	R		Originator Application Transaction Identifier
BHT04	R		Transaction Set Creation Date will not be used to determine the age of the claim. The received date will be compared to the service dates on the service lines to determine claim age. This date must be equal to or after the month and year of each date of service in the transaction.
BHT05	R		Transaction Set Creation Time
BHT06	R	CH	Claim or Encounter Identifier- CH=only value for claiming Medi-Cal.

Segment Name		**Transaction Type Identification**	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the X12N version for test and production.	
Example		REF*87*004010x098A1~	
Element ID	Usage	Valid Values	Comments
REF01	R	87	Reference Identification Qualifier – Functional Category
REF02	R	004010X098A1	Transmission Type Code The test value must be 004010X098DA1 (This test value is also indicated in ISA15).

Segment Name		**Submitter Name**	
Segment ID		NM1	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This will either be a County or a clearinghouse.	
Example		NM1*59*2*YORK COUNTY HEALTH CARE AGENCY*****46*59~	
Element ID	Usage	Valid Values	Comments
NM101	R	41	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 1 – Person 2 –Non person
NM103	R	Example: YORK COUNTY HEALTH CARE AGENCY	Submitter Last Name or Organization Name assigned to County
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	46	Identification Code
NM109	R		Submitter Identifier County Code. See Table O

Segment Name	**Submitter EDI Contact Information**		
Segment ID	PER		
Loop ID	1000A		
Segment Usage	Required		
Segment Notes	Submitter EDI Contact Information		
Example	PER*IC*FERMIN*TE*1234567890*EM*abc@AAA.COM~		
Element ID	Usage	Valid Values	Comments
PER01	R	IC	IC – Information Contact
PER02	R		Submitter Contact Name Can use "Billing Department"
PER03	R	TE	Communication Number Qualifier Values Used: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated Submitter's option
PER04	R		Submitter's Communication Number 4155558963
PER05	S	Not Used	Communication Number Qualifier Values: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated
PER06	S	Not Used	Communication Number
PER07	S	Not Used	Communication Number Qualifier Values: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated
PER08	S	Not Used	Communication Number

Segment Name		**Receiver Name**	
Segment ID		NM1	
Loop ID		1000B	
Segment Usage		Required	
Segment Notes		Receiver of this Transaction	
Example		NM1*40*2*DMH*****46* INFOTECHWEBSVCS	
Element ID	Usage	Valid Values	Comments
NM101	R	40	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 2 = Non Person Entity
NM103	R	DMH	Enter DMH
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	46	Identification Code Qualifier
NM109	R	INFOTECHWEBSVCS	Receiver Identifier Use this value.

Segment Name		**Billing/Pay-To Provider Hierarchical Level**	
Segment ID		HL	
Loop ID		2000A	
Segment Usage		Required	
Segment Notes		Billing Pay-To Hierarchical Level	
Example		HL*1**20*1~	
Element ID	Usage	Valid Values	Comments
HL01	R	1	Hierarchical ID Number Must begin with 1 and increment by one each time an HL is used.
HL02	N/A	Not Used	Hierarchical Parent ID Number
HL03	R	20	Hierarchical Level Code
HL04	R	1	Hierarchical Child Code

Segment Name		**Billing Pay-To Provider Specialty Information**	
Segment ID		PRV	
Loop ID		2000A	
Segment Usage		Situational	
Segment Notes		**Note 1:** If either the Billing or Pay-to Provider is also the Rendering Provider (i.e., Loops 2310B or 2420A are not populated), then this segment is required to pass HIPAA validation. Otherwise it can be left blank. **Note 2:** Needed to identify hospital outpatient (mode of service 12) vs. other outpatient (Mode of Service 18). If services are Outpatient Hospital (Mode 12) then a taxonomy code of 282N00000X or 283Q00000X must be used. Any other taxonomy code (or none) will be considered Mode 18. **Note 3:** Do not populate taxonomy at this level if there is a mix of hospital outpatient and other outpatient on the 837.	
Example		PRV*PT*ZZ*	
Element ID	Usage	Valid Values	Comments
PRV01	R	PT	Provider Code BI = Billing, PT = Pay-To
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		Reference Identification: 282N00000X = general hospital 283Q00000X = psychiatric hospital. For non-24-hour services: Either value will set mode of service to 12. Any other value will set mode of service to 18.

Segment Name	**Billing Provider Name**
Segment ID	NM1
Loop ID	2010AA
Segment Usage	Required
Segment Notes	**Standard Mode:** 1. Identify the County Mental Health Plan by Employer Identification Number (EIN) in NM108 and NM109 of this segment. 2. The SD/MC Provider Number (if provided) must be in element REF02 of loop 2010AA. **Dual Use Mode:** 1. The NPI of the County mental health plan (if provided) must be in NM108 and NM109. 2. If the Billing Provider NPI is provided, then the Employer Identification Number (EIN) must be in element REF02 of loop 2010AA; otherwise, the EIN must be provided here. 3. The SD/MC Provider Number (if provided) must be in element REF02 of loop 2010AA. **NPI Mode:** 1. Identify the County Mental Health Plan by NPI in NM108 and NM109. 2. The Employer Identification Number (EIN) must be in element REF02 of loop 2010AA. 3. The SD/MC Number must not be provided.
Example	NM1*85*2*YORK COUNTY HEALTH CARE AGY*****XX*9560009289~

Element ID	Usage	Valid Values	Comments
NM101	R	85	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 1=person, 2=non person
NM103	R		Billing Provider Name. This will be passed to the 835 if Loop 2010AB is not used.
NM104	N/A	Not Used	Biller First Name
NM105	N/A	Not Used	Biller Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	24, XX	Identification Code Qualifier 24 = EIN XX = NPI
NM109	R	NPI or EIN	Billing Provider ID This information will be passed to the 835 if the Pay-To Provider Loop is not sent.

Segment Name		**Billing Provider Address**	
Segment ID		N3	
Loop ID		2010AA	
Segment Usage		Required	
Segment Notes		Billing Provider Address	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Billing Provider Address Information
N302	S		Required if Second Address Line exists

Segment Name		**Billing Provider City/State/Zip**	
Segment ID		N4	
Loop ID		2010AA	
Segment Usage		Required	
Segment Notes		Billing Provider City/State/ZIP	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name
N402	R		State or Province Code
N403	R		Postal Code
N404	S	Not Used	County Code

Segment Name		**Billing Provider Secondary Identification**	
Segment ID		REF	
Loop ID		2010AA	
Segment Usage		Situational	
Segment Notes		**Standard Mode:** The SD/MC Provider Number (if provided) must be in element REF02 of this segment. **Dual Use Mode:** 1. If the County Mental Health Plan is identified by NPI in NM108 and NM109, then the EIN must be in element REF02 of this segment. 2. The SD/MC Provider Number (if provided) must be in REF02 of this segment. 3. If both EIN and SD/MC Provider Number are present, 2 REF segments will result. **NPI Mode:** 1. Identify the County Mental Health Plan by NPI in NM108 and NM109. 2. The Employer Identification Number (EIN) must be in REF02 of this segment. 3. The SD/MC Provider Number must not be provided.	
Example 1		REF*EI*123456789 ~	
Example 2		REF*1D*5934 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D or EI	Reference Identification Qualifier 1D = Medicaid Provider Number EI = Employer Identification Number.

REF02	R	EIN must be 9 characters. SD/MC Provider Number must be 4 characters.	EIN or SD/MC Provider Number:

Segment Name	**Pay-To Provider Name**
Segment ID	NM1
Loop ID	2010AB
Segment Usage	Situational
Segment Notes	If it is used to reflect County Treasurer as a separate entity, it will not be used by DMH to pay. Required only if the Pay-to Provider is different than the Billing Provider. **Standard Mode:** 1. Identify the Pay-to Provider by Employer Identification Number (EIN) in NM108 and NM109 of this segment. 2. The SD/MC Provider Number of the Pay-to Provider (if provided) must be in element REF02 of loop 2010AB. **Dual Use Mode:** 1. The NPI of the Pay-to Provider (if provided) must be in NM108 and NM109. 2. If the Pay-to Provider NPI is provided, then the Employer Identification Number (EIN) must be in element REF02 of loop 2010AB; otherwise, the EIN must be provided here. 3. The SD/MC Number of the Pay-to Provider (if provided) must be in element REF02 of loop 2010AB. **NPI Mode:** 1. Identify the Pay-to Provider by NPI in NM108 and NM109 of this segment. 2. The EIN of the Pay-to Provider must be in REF02 of loop 2010AB. 3. The SD/MC Number must not be provided.
Example	NM1*85*2*YORK COUNTY HEALTH CARE AGY*****XX*9560009289~

Element ID	Usage	Valid Values	Comments
NM101	R	87	Entity Identifier Code Not used in SD/MC
NM102	R	2	Entity Type Qualifier Not used in SD/MC
NM103	R		Pay-To Provider Name This will be passed to the 835 if sent.
NM104	N/A	Not Used	Pay-To Provider First Name Not used in SD/MC
NM105	N/A	Not Used	Pay-To Provider Middle Name Not used in SD/MC
NM106	N/A	Not Used	*
NM107	N/A	Not Used	Pay-To Provider Name Suffix Not used in SD/MC
NM108	R	24, XX	Identification Code Qualifier 24 = EIN XX = NPI
NM109	R		Pay-To Provider ID This will be passed to the 835 if sent; otherwise billing provider will be sent.

Segment Name		**Pay-To Provider Address**	
Segment ID		N3	
Loop ID		2010AB	
Segment Usage		Situational	
Segment Notes		Billing Provider Address	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Provider Address Information
N302	S		Required if Second Address Line exists
Segment Name		**Pay-To Provider City/State/Zip**	
Segment ID		N4	
Loop ID		2010AB	
Segment Usage		Situational	
Segment Notes		Billing Provider City/State/ZIP	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name
N402	R		State or Province Code
N403	R		Postal Code

Segment Name		**Pay-To Provider Secondary Identification**	
Segment ID		REF	
Loop ID		2010AB	
Segment Usage		Situational	
Segment Notes		This segment only needs to be populated if the Pay-to Provider is different than the Billing Provider and the Pay-to Provider is the same as the service facility location for all services on the claim. Otherwise the provider identifier will be extracted from the Claim Loops (2310D). **Standard Mode:** The SD/MC Provider Number (if provided) must be in element REF02 of this segment. **Dual Use Mode:** 1. If the Pay-to Provider is identified by NPI in NM108 and NM109 of loop 2010AB, then the EIN must be in element REF02 of this segment. 2. The SD/MC Provider Number (if provided) must be in REF02 of this segment. 3. If both EIN and SD/MC Provider Number are present, 2 REF segments will result. **NPI Mode:** 1. Identify the County Mental Health Plan by NPI in NM108 and NM109 of loop 2010AB. 2. The EIN must be in REF02 of this segment. 3. The SD/MC Provider Number must not be provided.	
Example		REF*1D*5996 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D or EI	Reference Identification Qualifier 1D = Medicaid Provider Number EI = Employer Identification Number.
REF02	R	EIN must be 9 characters. SD/MC Provider Number must be 4 characters.	EIN or SD/MC Provider Number:

Segment Name		**Subscriber Hierarchical Level**	
Segment ID		HL	
Loop ID		2000B	
Segment Usage		Required	
Segment Notes		Subscriber Hierarchical Level	
Example		HL*2*1*22*0~	
Element ID	Usage	Valid Values	Comments
HL01	R	2	Hierarchical ID Number Increment by 1 for each HL segment in transaction
HL02	N/A	1	Hierarchical Parent ID Number Use the HL01 value of the Billing/Pay-To Provider in 2000A
HL03	R	22	Hierarchical Level Code
HL04	R	0	Hierarchical Child Code The subscriber is always the patient for DMH.

Segment Name		**Subscriber Information**	
Segment ID		SBR	
Loop ID		2000B	
Segment Usage		Required	
Segment Notes		Subscriber Information	
Example		SBR*P*18*******MB~	
Element ID	Usage	Valid Values	Comments
SBR01	R	P	Payer Responsibility Do not use S or T unless COB information is included on the claim.
SBR02	R	18	Individual Relationship Code
SBR03	N/A	Not used	Insured Group or Policy Number
SBR04	N/A	Not used	Group or Plan Name
SBR05	N/A	Not used	Insurance Type Code
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	R	MB	Claim Filing Indicator Code

Segment Name		**Subscriber Name**	
Segment ID		NM1	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This segment identifies the subscriber and must include the Subscriber Identification Number.	
Example		NM1*IL*1*DOE* JOHN****MI*596009244900334~	
Element ID	Usage	Valid Values	Comments
NM101	R	IL	Entity Identifier Code IL = Insured or Subscriber
NM102	R	1	Entity Type Qualifier Must use a value of 1 (person) for SD/MC. (2 = non-person)
NM103	R		Subscriber Last Name or Organization
NM104	S		Subscriber First Name
NM105	N/A		Subscriber Middle Name Can be middle initial or blank
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	MI	Identification Code Qualifier MI = Member ID
NM109	R		Subscriber Identifier: The same Beneficiary ID formats may be used under HIPAA as in the MEDS. The preferred format is the Client Index Number (CIN). Also, to comply with the HIPAA Privacy Rule's minimum necessary disclosure of client identifiable information, it is recommended that the SSN not be used. **Acceptable Beneficiary Identification Formats for SD/MC:** 1. County code, aid code, case, FBU, person number Example: 193R0686666011(19-3R-068666-0-11) 2. County code, aid code, "9", followed by SSN Example: 11609563600020 (11-60-9-563600020) 3. County code, aid code, "M", followed by MEDS ID or Pseudo MEDS ID Example: 1330M87940123P (13-30-M-87940123P) 4. County code, aid code, C", followed by CIN Example: 1330C98630052A (13-30-C-98630052A) 5. SSN or MEDS-ID or CIN Example: 563600020 Example: 87940123P Example: 98630052A 6. County code,"9H", "9", followed by the CIN for Healthy Families. This format is required to submit a claim for Healthy Families Program reimbursement and indicates a mental health SED service. Example: 599H998630052A (59-9H-9-98630052A)

Segment Name		**Subscriber Address**	
Segment ID		N3	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This is required due to situational notes, but is not used in SD/MC.	
Example		N3*250 E WASHINGTON BLVD~	
Element ID	Usage	Valid Values	Comments
N301	R		Subscriber Address Line HOMELESS may be used if appropriate.
N302	S		Subscriber Address 2

Segment Name		**Subscriber City/State/Zip**	
Segment ID		N4	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This is required due to situational notes, but is not used in SD/MC.	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name If unknown, use the provider's city.
N402	R		State or Province Code
N403	R		Postal Code If unknown, use the provider's postal code.

Segment Name		**Subscriber Demographic Information**	
Segment ID		DMG	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This segment identifies the Subscriber Demographic Information.	
Example		DMG*D8*19540506*M~	
Element ID	Usage	Valid Values	Comments
DMG01	R	D8	Date expressed in format CCYYMMDD
DMG02	R	20030214	Subscriber Birth Date
DMG03	R		Subscriber Gender Identification Valid Values: M – Male F – Female U - Unknown

Segment Name		**Payer Name**	
Segment ID		NM1	
Loop ID		2010BB	
Segment Usage		Required	
Segment Notes		This segment identifies the payer and must include the Payer Identification Number.	
Example		NM1*PR*2*DMH*****PI*01~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR	Entity Identifier Code PR = Payer
NM102	R	2	Entity Type Qualifier 2 = Non Person
NM103	R	DMH	Organization Name Use DMH
NM104	N/A	Not Used	Subscriber First Name
NM105	N/A	Not Used	Subscriber Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI	Identification Code Qualifier PI = Payer Identification
NM109	R	01	Payer Primary ID Use 01 - DMH, Mental Health Services

Segment Name		**Claim Information**	
Segment ID		CLM	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This loop should be subordinate to Loop 2000B for SD/MC	
Example		CLM*1887*2361.58***55::1*Y*A*Y*Y*P**********1~	
Element ID	Usage	Valid Values	Comments
CLM01	R		Patient Account Number CML01 (Patient account number or claim number) is copied to CLP01 on the 835 so that the claim can be matched to the payment information on the 835.
CLM02	R		Total Claim Amount
CLM03	N/A	Not Used	Not Used
CLM04	N/A	Not Used	Not Used
CLM05	R		Place of Service Code
CLM05-01	R		Facility Type Code: Used in SD/MC if service line POS not used. Check the Service Code Crosswalk for specific codes that may be necessary depending on the services rendered. Otherwise, any valid code may be used.
CLM05-02	N/A	Not Used	Not Used
CLM05-03	R	1	All claims are processed as originals.
CLM06	R	Y	Provider Signature on File Always use Y unless DMH instructions indicate otherwise. Need signature on file at County for authority to bill to SD/MC

CLM07	R		Medicare Assignment Code In the absence of COB information (Loop2320), a value of C (Not Assigned) equals H (Non-Medicare certified provider) in SD/MC
CLM08	R	Y	Assignment of Benefit Indicator Always use Y unless DMH instructions indicate otherwise.
CLM09	R		Release of Information Code I = informed consent, Y = signature on file
CLM10	S	P	Patient Signature Source Code As recommended by federal Office of Civil Rights
CLM20	S	1	Delay Reason Code See Crosswalk Example : 1 Only required if needed to provide the reason why a claim was submitted late.

Segment Name		**Date – Admission**	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		DMH - Required on every 24-hour claim (Mode 05). Also required if Place of Service code (CLM05-1) equals 21.	
Example		DTP*435*D8*20030915~	
Element ID	Usage	Valid Values	Comments
DTP01	R	435	Date/Time Qualifier
DTP02	R	D8	Date/Time Format Date expressed in format CCYYMMDD
DTP03	R		Date Time Period

Segment Name		**Date – Discharg**e	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		DMH - 24 Hours Only (Mode 05); To be included on the last claim for the encounter. Do not submit with services that are not Mode 05.	
Example		DTP*096*D8*20030915~	
Element ID	Usage	Valid Values	Comments
DTP01	R	096	Date/Time Qualifier
DTP02	R	D8	Date/Time Format Date expressed in format CCYYMMDD
DTP03	R		Date Time Period

Segment Name		**Patient Amount Paid**	
Segment ID		AMT	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		This is required if the Patient has Paid any amount towards the claim	
Example		AMT*F5*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	F5	Amount Qualifier Code Medi-Cal share of cost (SOC)
AMT02	R	152.45	Patient Amount Paid; Medi-Cal share of cost (SOC). This will be placed on the 835 if provided.

Segment Name		**Medical Record Number**	
Segment ID		REF	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This segment Identifies the patient's Medical Record Number.	
Example		REF*EA*7251A001~	
Element ID	Usage	Valid Values	Comments
REF01	R	EA	Reference Identification Qualifier
REF02	R		Medical Record Number Enter the County Patient Medical Record number here. Chart # Match to CSI Used for audits

Segment Name		**Claim Note**	
Segment ID		NTE	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. Although not required, the FFS and ASO-FC indicators are needed in order to perform the alternate crosswalk for FFS and ASO-FC Providers in Dual-Use Mode and NPI Mode.	
Example		NTE*ADD*FFS~	
Element ID	Usage	Valid Values	Comments
NTE01	R	ADD	Additional Information
NTE02	R	FFS or ASO-FC	FFS = Fee For Service ASO-FC = ASO Foster Care

Segment Name		**Health Care Information Code**	
Segment ID		HI	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		This is required on all claims with few exceptions. Do not send decimal points. The actual diagnosis pulled for a specific service will depend on the diagnosis pointer in SV107.	
Example		HI*BK:2956~	
Element ID	Usage	Valid Values	Comments
HI01-01	R	BK	Code List Qualifier Code
HI01-02	R		Industry Standard Code Value according to ICD-9 codes
HI02-01	S		Code List Qualifier Code
HI02-02	S		Industry Standard Code Value according to ICD-9 codes
HI03-01	S		Code List Qualifier Code
HI03-02	S		Industry Standard Code Value according to ICD-9 codes
HI04-01	S		Code List Qualifier Code
HI04-02	S		Industry Standard Code Value according to ICD-9 codes
HI05-01	S		Code List Qualifier Code
HI05-02	S		Industry Standard Code Value according to ICD-9 codes
HI06-01	S		Code List Qualifier Code
HI06-02	S		Industry Standard Code Value according to ICD-9 codes
HI07-01	R		Code List Qualifier Code
HI07-02	R		Industry Standard Code Value according to ICD-9 codes
HI08-01	R		Code List Qualifier Code
HI08-02	R		Industry Standard Code Value according to ICD-9 codes

Segment Name		**Rendering Provider Name**	
Segment ID		NM1	
Loop ID		2310B	
Segment Usage		Situational	
Segment Notes		**Standard Mode:** Identify the Rendering Provider by (EIN), SSN, or NPI in NM108 and NM109 of this segment. **Dual-Use Mode:** 1. Identify the Rendering Provider by NPI in NM108 and NM109 of this segment. 2. The Employer Identification Number (EIN), if provided, must be in element REF02 of loop 2310B. **NPI Mode:** 1. Identify the Rendering Provider by NPI in NM108 and NM109 of this segment. The EIN, if provided, must be in element REF02 of loop 2310B. The following information is required in order to perform an alternate crosswalk for FFS providers and is applicable in both Dual-Use and NPI mode. Otherwise, it is not required. **Note 1 – For FFS Group Practices enter:** A 2 (non-person) in NM102 (Entity Type Qualifier), The Group's NPI in NM109, The Group's Taxonomy Code in 2310B PRV03 The NPI(s) of the person(s) who rendered the service in element NM109 of loop 2420A. **Note 2 - For FFS Sole Proprietor/Proprietorship enter:** A 1 (person) in NM102 (Entity Type Qualifier), The Sole Proprietor/Proprietorship NPI in NM109, The Sole Proprietor/Proprietorship Taxonomy Code in element PRV03 in loop 2310B. **Note 3 - If multiple persons provide services, populate loop 2420A.**	
Example		NM1*82*1*DOE*JOHN****XX*9000000001~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code
NM102	R	1 or 2.	Entity Type Qualifier: 1 = person 2 = non-person
NM103	R		Counselor's last name
NM104	S		Counselor's first name
NM105	S	Not Used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R	24, 34, XX	Rendering Provider ID: 24 = EIN 34 = SSN XX = NPI.
NM109	R		EIN, SSN, or NPI of the person or group providing the service.

Segment Name		**Rendering Provider Specialty Information**	
Segment ID		PRV	
Loop ID		2310B	
Segment Usage		Situational	
Segment Notes		**Note 1:** Identify hospital outpatient (mode of service 12) with either 282N00000X for general hospital or 283Q00000X for psychiatric hospital. **Note 2:** The taxonomy code for FFS providers is required in order to perform an alternate crosswalk and is applicable in both Dual-Use and NPI mode. Otherwise, the taxonomy code is not required.	
Example		PRV*ZZ*103TC0700X~	
Element ID	Usage	Valid Values	Comments
PRV01	R	PE	Provider Code
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		282N00000X = general hospital 283Q00000X = psychiatric hospital For non-24-hour services: Either value will set mode of service to 12, any other value will set mode of service to 18. For FFS providers, enter the taxonomy code of the group practice or sole proprietorship here. 2084P0800X = Psychiatry (psychiatrist) 103T00000X = Psychologist 163W00000X = Registered Nurse 106H00000X = Marriage & Family Therapist 1041C0700X = Social Worker – Clinical (LCSW) 193200000X = Group – Multi-Specialty (Mixed)

Segment Name		**Service Facility Location (SFL)**	
Segment ID		NM1	
Loop ID		2310D	
Segment Usage		Situational	
Segment Notes		This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. **Standard Mode:** 1. Identify the Service Facility Location by EIN or SSN in NM108 and NM109 of this segment. 2. The SD/MC Provider Number must be in element REF02 of loop 2310D. **Dual Use Mode:** 1. If the Service Facility Location is identified by NPI, then the NPI must appear in NM108 and NM109 of this segment. 2. If the Service Facility Location is identified by NPI, then the EIN or SSN (if provided) must be in element REF02 of loop 2310D. Otherwise, the EIN or SSN of the provider would go in this segment. 3. The SD/MC Provider Number (if provided) must be in element REF02 of loop 2310D. **NPI Mode:** 1. Identify the Service Facility Location by NPI in NM108 and NM109 of this segment. 2. The EIN or SSN (if provided) must be in element REF02 of loop 2310D. 3. The SD/MC Number must not be provided.	
Example		NM1* FA*2*A-OK MENTAL HEALTH CLINIC*****XX*1112233344~	
Element ID	Usage	Valid Values	Comments
NM101	R	FA	Entity Identifier Code Other codes used 77 – Service Location FA – Facility LI – Independent Lab TL – Testing Lab
NM102	R	2	Entity Type Qualifier
NM103	S	A-OK MENTAL HEALTH CLINIC	Organization Name Required except when service was rendered in the patient's home.
NM104	N/A	Not Used	
NM105	N/A	Not Used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	S	XX, 24, 34	Identification Code Qualifier
NM109	R		Identification Code XX = NPI 24= EIN 34=SSN

Segment Name		**Service Facility Location Secondary Identification**	
Segment ID		REF	
Loop ID		2310D	
Segment Usage		Situational	
Segment Notes		This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. **Standard Mode:** The SD/MC Provider Number must be in element REF02 of this segment. **Dual Use Mode:** The SD/MC Provider Number (if provided) must be in element REF02 of this segment. **NPI Mode:** 1. Identify the Service Facility Location by NPI in NM108 and NM109 of loop 2310D. 2. The SD/MC Provider Number must not be provided.	
Example		REF*ID*9999~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Number
REF02	R	9999	Laboratory/Facility Secondary ID The SD/MC Provider Number (if provided) goes here.

Segment Name		**Other Subscriber Information**	
Segment ID		SBR	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Only use for COB situations, including indication of Medicare or Other Health Coverage denial.	
Example		SBR*P*18***MB****MB~	
Element ID	Usage	Valid Values	Comments
SBR01	R	P	Payer Responsibility Sequence Number Code
SBR02	R	18	Individual Responsibility Code
SBR03	N/A	Not used	
SBR04	N/A	Not used	
SBR05	R	MB	Insurance Type Code
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	N/A	See Table D: Crossover Indicator Crosswalk.	Claim Filing Indicator Code

Segment Name		**Payer Paid Amount**	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Required if claim has been adjudicated by the payer identified in this loop. It is acceptable to show "0" amount paid.	
Example		AMT*D*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	D	Amount Qualifier Code
AMT02	R		Payer Paid Amount Submitters - Crosswalk from CLP04 in 835 when doing COB. This will only be used if line level COB payment information is not available. This segment is required to pass HIPAA validation if doing COB. For non-covered services use zero (0) to satisfy the requirements.

Segment Name		**Allowed Amount**	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Only used to identify situations where a Medicare recipient is receiving services from a Medicare provider that are denied or not covered by Medicare.	
Example		AMT*B6*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	B6	Amount Qualifier Code B6 = Allowed-Actual
AMT02	R		Allowed Amount If the value is equivalent to zero, and Medicare is indicated in the COB data, this equals "N" Crossover Indicator value in SD/MC.

Segment Name		**Patient Responsibility**	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1)	
Example		AMT*F2*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	F2	Amount Qualifier Code F2 = Patient Responsibility -Actual
AMT02	R		Monetary Amount

Segment Name		**Other Subscriber Information**	
Segment ID		DMG	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		This segment identifies the Subscriber Demographic Information.	
Example		DMG*D8*19540506*M~	
Element ID	Usage	Valid Values	Comments
DMG01	R	D8	Date Time Period Format Qualifier
DMG02	R		Other Insured Birth Date
DMG03	R		Other Insured Gender Code Valid Values: M – Male F – Female U - Unknown
DMG04	N/A	Not Used	Marital Status Code
DMG05	N/A	Not Used	Race or Ethnicity Code
DMG06	N/A	Not Used	Citizenship Status Code
DMG07	N/A	Not Used	Country Code
DMG08	N/A	Not Used	Basis of Verification Code
DMG09	N/A	Not Used	Quantity

Segment Name		**Other Insurance Coverage Information**	
Segment ID		OI	
Loop ID		2320	
Usage		Situational	
Segment Notes		This information applies only to the Payer of the Claim.	
Example		OI***Y*B**Y~	
Element ID	Usage	Valid Values	Comments
OI01	N/A	Not Used	
OI02	N/A	Not Used	
OI03	R	Y	Yes/No Condition or Response Valid Values: Y – Yes N - No
OI04	R	B	Patient Signature Source Code
OI05	N/A	Not Used	
OI06	R	Y	Release of Information Code

Segment Name		**Other Subscriber Name**	
Segment ID		NM1	
Loop ID		2330A	
Usage		Situational	
Segment Notes		This segment identifies Other Subscriber Information in the Claim.	
Example		NM1* IL*1*DOE*JOHN****MI*19609244900334~	
Element ID	Usage	Valid Values	Comments
NM101	R	IL – Insured or Subscriber	Entity Identifier Code
NM102	R	1 – Person	Entity Type Qualifier
NM103	R	DOE	Submitter Last Name or Organization Name
NM104	N/A	JOHN (Not used)	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	MI	Identification Code Qualifier
NM109	R	19609244900334	Sender Identifier

Segment Name		**Other Payer Name**	
Segment ID		NM1	
Loop ID		2330B	
Usage		Situational	
Segment Notes		This segment identifies Other Payer Information in the Claim.	
Example		NM1* PR*2*MEDI-CAL*****PI*951234567~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR - Payer	Entity Identifier Code
NM102	R	2 – Non-Person Entity	Entity Type Qualifier
NM103	R	MEDI-CAL	Submitter Last Name or Organization Name
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI- Payer IDENTIFICATION	Identification Code Qualifier
NM109	R	951234567	Payer Identifier

Segment Name		**Date – Service Date**	
Segment ID		DTP	
Loop ID		2330B	
Segment Usage		SITUATIONAL	
Segment Notes		This segment is used to specify a time period.	
Example		DTP*573*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	573	Date/Time Qualifier
DTP02	R	D8	Date Time Period Format Qualifier.
DTP03	R		Date/Time Period

Segment Name		**Service Line**	
Segment ID		LX	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment identifies Service Lines in a Claim.	
Example		LX*1~	
Element ID	Usage	Valid Values	Comments
LX01	R	1	Line Counter Start with 1 and increment by 1 for each service line on the claim.

Segment Name		**Professional Service**	
Segment ID		SV1	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment specifies claim service detail.	
Example		SV1*HC:H0019:HE:HB*2361.58*UN*31*56**1~	
Element ID	Usage	Valid Values	Comments
SV101-01	R	HC	Product/Service ID Qualifier HC only code used. Other valid values are not used in SD/MC.
SV101-02	R		Procedure Code See Crosswalk
SV101-03	S		Procedure Modifier 1; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-04	S		Procedure Modifier 2; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-05	S		Procedure Modifier 3; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-06	S		Procedure Modifier 4 See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV102	R		Line Item Charge Amount. Values exceeding six places to the left of the decimal cannot be processed correctly by SD/MC.
SV103	R		Unit or Basis for Measurement UN=Unit See Crosswalk
SV104	R		Service Unit Count See Crosswalk.
SV105	S		Place of Service Code Only required if the Place of Service differs from the value provided in CLM05-1. Check the Service Code Crosswalk for specific codes that may be necessary depending on the services rendered. Otherwise, any valid code may be used.
SV106	N/A	Not Used	Service Type Code Not Used
SV107-01	S		Diagnosis Code Pointer This value determines which diagnosis code provided in Loop 2300 will be used for processing. If only one diagnosis is submitted, this value should be "1"
SV108	N/A	Not Used	Monetary Amount is Not Used
SV109	S		Emergency Indicator Not used in SD/MC

Segment Name		**Date – Service Date**	
Segment ID		DTP	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment is used to specify a time period.	
Example		DTP*472*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	472	Date/Time Qualifier
DTP02	R	D8, RD8	D8=CCYYMMDD RD8=CCYYMMDD-CCYYMMDD RD8 should only be used for Mode 05(24-Hour Non-Hospital Services).
DTP03	R	With D8: 20030314; with RD8: 20030314-20030322	Date/Time Period For DMH residential services when using a date range (RD8) the month and year for the "from" and "to" dates must be the same. (Claims cannot cross over months)

Segment Name		**Line Item Control Number**	
Segment ID		REF	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This Segment is the Provider Control Number.	
Example		REF*6R*31063~	
Element ID	Usage	Valid Values	Comments
REF01	R	6R	Reference Identification Number
REF02	R		Unique ID across all service lines. Due to current SD/MC limitations, the first 5 characters must be numeric and the maximum length is 23 characters. All 30 characters will be passed through to the 835. Only alphanumeric and certain special characters are allowed. Lowercase characters will be converted to uppercase. Portions of the Line Item Control Number map to the following fields on the SD/MC EOB: A) Line Item Control Number characters 1 through 5 map to characters 6 through 10 of the SD/MC Claim ID Serial Number. B) Line Item Control Number characters 6 through 20 map to SD/MC County Use 1. C) Line Item Control Number characters 21 through 23 map to SD/MC County Use 2.

Segment Name		**Rendering Provider Name**	
Segment ID		NM1	
Loop ID		2420A	
Segment Usage		Situational	
Segment Notes		Use this loop when claiming for services where the billing unit is based on staff time. You may repeat the loop two times to indicate up to two staff people. If more than two staff were involved in delivering the service then multiple service lines should be used to report all staff involved in providing the service. The types of services which are based on staff time are: Case Management, MHS, TBS, Medication Support, and Crisis Intervention.	
Example		NM1* 82*1*SMITH*JUNE*L***XX*9876543210~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code
NM102	R	1 or 2	Entity Type Qualifier 1 = person 2 = non-person
NM103	R		Rendering Provider Last or Org Name
NM104	S		Rendering Provider First Name Required when the provider is a person.
NM105	S		Rendering Provider Middle Name
NM106	N/A	Not Used	Rendering Provider Name Prefix
NM107	S		Rendering Provider Name Suffix
NM108	R	XX	Identification Code Qualifier XX = NPI.
NM109	R		NPI of the person or group providing the service.

Segment Name		**Rendering Provider Specialty Information**	
Segment ID		PRV	
Loop ID		2420A	
Segment Usage		Situational	
Segment Notes			
Example		PRV*PT*ZZ*282N00000X~	
Element ID	Usage	Valid Values	Comments
PRV01	R	PE	Provider Code
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		

Segment Name		**Service Facility Location**	
Segment ID		NM1	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		NM1* TL*2*A-OK MOBILE CLINIC*****XX*1112233344~	
Element ID	Usage	Valid Values	Comments
NM101	R	TL	Entity Identifier Code
NM102	R	2	Entity Type Qualifier
NM103	R		Submitter Last Name or Organization Name Not used in SD/MC, but still a required part of Loop 2420C
NM104	N/A	Not used	
NM105	N/A	Not used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R	XX	Identification Code Qualifier XX = NPI
NM109	R		Service Facility Location ID Number Service Facility Location NPI.

Segment Name		**Service Facility Location Address**	
Segment ID		N3	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Service Facility Location Address 1 Not used in SD/MC, but still a required part of Loop 2420C
N302	S		Service Facility Location Address 2

Segment Name		**Service Facility Location City/State/ ZIP**	
Segment ID		N4	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		Service Facility Location City Not used in SD/MC, but still a required part of Loop 2420C
N402	R		Service Facility Location State Not used in SD/MC, but still a required part of Loop 2420C
N403	R		Service Facility Location ZIP Not used in SD/MC, but still a required part of Loop 2420C

Segment Name		**Service Facility Location Secondary ID**	
Segment ID		REF	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes			
Example		REF*1D*8096 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Qualifier
REF02	R		Service Facility Location Secondary ID Not used in SD/MC

Segment Name		**Line Adjudication Information**	
Segment ID		SVD	
Loop ID		2430	
Segment Usage		Situational	
Segment Notes		Used for Medicare and other Health Coverage amount.	
Example		SVD*43*55*HC: 90829**3~	
Element ID	Usage	Valid Values	Comments
SVD01	R	43	Other Payer Primary ID
SVD02	R	55	Service Line Paid Amount This is the primary value that will be used if available.
SVD03	R		Procedure Identifier
SVD03-01	R	HC	Product or Service ID Qualifier
SVD03-02	R	90829	Procedure Code
SVD03-03	S		Procedure Modifier 1
SVD03-04	S		Procedure Modifier 2
SVD03-05	S		Procedure Modifier 3
SVD03-05	S		Procedure Modifier 4
SVD03-06	S		Procedure Code Description
SVD04	N/A	NOT USED	
SVD05	S		Paid Units of Service
SVD05	S		Bundled Line Number

Segment Name		**Line Adjustment**	
Segment ID		CAS	
Loop ID		2430	
Segment Usage		Situational	
Segment Notes		PR (Patient Responsibility)	
Example		CAS*PR*2*5.25	
Element ID	Usage	Valid Values	Comments
CAS01	R		Claim Adjustment Group Code
CAS02	R		Adjustment Reason Code
CAS03	R		Adjustment Amount
CAS04	S		Adjustment Quantity
CAS05	S		Adjustment Reason Code
CAS06	S		Adjustment Amount
CAS07	S		Adjustment Quantity
CAS08	S		Adjustment Reason Code
CAS09	S		Adjustment Amount
CAS10	S		Adjustment Quantity
CAS11	S		Adjustment Reason Code
CAS12	S		Adjustment Amount
CAS13	S		Adjustment Quantity
CAS14	S		Adjustment Reason Code
CAS15	S		Adjustment Amount
CAS16	S		Adjustment Quantity
CAS17	S		Adjustment Reason Code
CAS18	S		Adjustment Amount
CAS19	S		Adjustment Quantity

Segment Name		**Line Adjudication Date**	
Segment ID		DTP	
Loop ID		2430	
Segment Usage		Situational	
Segment Notes			
Example		DTP*573*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	573	Date Time Qualifier
DTP02	R		Date Time Period Format Qualifier
DTP03	R		Adjudication or Payment Date

Segment Name		**Transaction Set Trailer**	
Segment ID		SE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		Transaction Set Trailer Counts	
Example		SE*34*0001~	
Element ID	Usage	Valid Values	Comments
SE01	R		Number of Included Segments
SE02	R		Transaction Set Control Number Must match ST02 of this transaction

3.12.2 Example of an 837P Transaction

	Interchange Control Header (L_ISA)
	ISA*00* *00* *ZZ*C5900000000000*ZZ*INFOTECHWEBSVCS *030918*1659*U*00401*000000864*0*P*:~
	Functional Group Header (L_GS)
2	GS*HC*C5900000000000*INFOTECHWEBSVCS *20030918*105531*1*X*004010X098A1~
	Transaction Set Header (837P)
3	ST*837*0001~
4	BHT*0019*00*4144000001*20030826**CH~
5	REF*87*004010X098A1~
	Submitter Name (1000A)
6	NM1*41*2*York County Health Care Agency*****46*59~
7	PER*IC*Billing Contact Person*TE*2135953450~
	Receiver Name (1000B)
8	NM1*40*2*DMH*****46*INFOTECHWEBSVCS~
	Billing/Pay-to Provider Hierarchical Level (2000A)
9	HL*1**20*1~
10	PRV*PT*ZZ*282N00000X~
	Billing Provider Name (2010AA)
11	NM1*85*2*Interconnection Center, Inc.*****XX*1234567890~
12	N3*3833 South Grand Avenue~
13	N4*Los Angeles*CA*90037~ REF*1D*9991
	Subscriber Hierarchical Level (2000B)
14	HL*2*1*22*0~
15	SBR*P*18*******MC~
	Subscriber Name (2010BA)
16	NM1*IL*1*Doe*John*K***MI*596009244900334~
17	N3*123 Bond Ave~
18	N4*Bayview*CA*95630~
19	DMG*D8*19481223*M~

Payer Name (2010BB)

NM1*PR*2*DMH*****PI*01~

Claim Information (2300)

CLM*A123B456*__300__***22::1*Y*C*Y*Y*P~

DTP*435*D8*20030501~

REF*EA*A1234B5678~

HI*BK:2956~

Service Facility Location (2310D)

NM1*FA*2*Interconnection Center, Inc.*XX*1112233344~

N3*3833 South Grand Avenue~

N4*Los Angeles*CA*90037~

REF*1D*9999~

Service Line (2400)

LX*1~

SV1*HC:S9484:HE:TG*__100__*UN*1*20**1~

DTP*472*D8*20030501~

REF*6R*31063~

Service Line (2400)

LX*2~

SV1*HC:S9484:HE:TG*__100__*UN*1*23**1~

DTP*472*D8*20030502~

REF*6R*31064~

Service Line (2400)

LX*3~

SV1*HC:H2012:HE*__100__*UN*4***1~

DTP*472*D8*20030503~

REF*6R*31065~

Claim Information (2300)

CLM*A123B457*123.12***22::1*Y*C*Y*Y*P~

DTP*435*D8*20030501~

REF*EA*A12345678~

44 HI*BK:2899~

Service Facility Location (2310D)

45 NM1*FA*2*Interconnection Center, Inc.~

46 N3*3833 South Grand Avenue~

47 N4*Los Angeles*CA*90037~

48 REF*1D*7019~

Service Line (2400)

49 LX*1~

50 SV1*HC:S9484:HE:TG*__100__*UN*1*20**1~

51 DTP*472*D8*20030501~

52 REF*6R*31063~

Service Line (2400)

53 LX*2~

54 SV1*HC:T1017:HE*23.12*UN*.87***1~

55 DTP*472*D8*20030502~

56 REF*6R*31064~

Transaction Set Trailer (837P)

57 SE*60*0001~

Functional Group Trailer (L_GS)

58 GE*1*1~

Interchange Control Trailer (L_ISA)

59 IEA*1*000000864~

3.13 837 INSTITUTIONAL CLAIMS AND ENCOUNTERS

The following table lists only those segments that are needed for submission of the 837I to DMH. Failure to include a required segment results in a compliance error. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Table 12: Segment Usage – 837 Institutional

SEGMENT ID	LOOP ID	SEGMENT NAME	R – REQUIRED S – SITUATIONAL	DESCRIPTION
ST	N/A	Transaction Set Header	R	See 837P
BHT	N/A	Beginning of Hierarchical Transaction	R	See 837P
REF	N/A	Transmission Type Identifier	R	
NM1	1000A	Submitter Name	R	See 837P
PER	1000A	Submitter EDI Contact Information	R	See 837P
NM1	1000B	Receiver Name	R	See 837P
HL	2000A	Billing/Pay-To Hierarchical Level	R	See 837P
PRV	2000A	Billing/Pay-to Provider Specialty Information	S	See 837P
NM1	2010AA	Billing Provider Name	R	See 837P
N3	2010AA	Billing Provider Address	R	See 837P
N4	2010AA	Billing Provider City/State/ZIP Code	R	See 837P
REF	2010AA	Billing Provider Secondary Information	R	See 837P
NM1	2010AB	Pay-To Provider Name	S	See 837P
N3	2010AB	Pay-To Provider Address	S	See 837P
N4	2010AB	Pay-To Provider City/State/ZIP Code	S	See 837P
REF	2010AB	Pay-To Provider Secondary Information	S	See 837P
HL	2000B	Subscriber Hierarchical Level	R	See 837P
SBR	2000B	Subscriber Information	R`	See 837P
NM1	2010BA	Subscriber Name	R	See 837P
N3	2010BA	Subscriber Address	R	See 837P
N4	2010BA	Subscriber City/State/ZIP Code	R	See 837P
DMG	2010BA	Subscriber Demographic Information	R	See 837P
NM1	2010BC	Payer Name	R	See 837P Loop 2010BB
CLM	2300	Claim Information	R	
DTP	2300	Discharge Hour	S	

SEGMENT ID	LOOP ID	SEGMENT NAME	R – REQUIRED S – SITUATIONAL	DESCRIPTION
DTP	2300	Statement Date	R	
DTP	2300	Admission Date/Hour	S	
CL1	2300	Institutional Claim Code	S	
AMT	2300	Patient Amount Paid	S	See 837P
REF	2300	Medical Record Number	S	See 837P
HI	2300	Principal, Admitting, E-Code-and Patient Reason for Visit Diagnosis Information	R	
NTE	2300	Claim Note	S	
NM1	2310A	Attending Physician Name	R	
NM1	2310E	Service Facility Location	S	See 837P 2310D
REF	2310E	Service Facility Location Secondary Identification	S	See 837P 2310D
SBR	2320	Other Subscriber Information	S	
CAS	2320	Claim Adjustments		
AMT	2320	Payer Prior Payment	S	
AMT	2320	Allowed Amount	S	See 837P
DMG	2320	Subscriber Demographic Information	S	See 837P
OI	2320	Other Insurance Coverage Information	S	See 837P
NM1	2330A	Other Subscriber Name	S	See 837P
NM1	2330B	Other Payer Name	S	See 837P
DTP	2330B	Claim Adjudication Date	S	See 837P
LX	2400	Service Line Number	R	See 837P
SV2	2400	Institutional Service Line	R	
SVD	2430	Line Adjudication Information	S	See 837P
CAS	2430	Line Adjustment	S	See 837P
DTP	2430	Line Adjudication Date	S	See 837P
SE	N/A	Transaction Set Trailer	R	See 837P

Segment Name		**Transaction Type Identification**	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the X12N version for test and production.	
Example		REF*87*004010X096A1~	
Element ID	Usage	Valid Values	Comments
REF01	R	87	Reference Identification Qualifier – Functional Category
REF02	R	004010x096A1	Transmission Type Code Test value should be 004010X098DA1 (Test also indicated in ISA15).

Segment Name		**Claim Information**	
Segment ID		CLM	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This loop should be subordinate to Loop 2000B for SD/MC. Because Institutional claims are limited to one service line loop per claim information loop, the Service Line Unique Identifier must appear in the Patient Account Number, element CLM01.	
Example		CLM*90001*826.78***11:A:1*Y*A*Y*Y*********N~	
Element ID	Usage	Valid Values	Comments
CLM01	R		Patient Account Number
CLM02	R		Total Claim Amount
CLM03	N/A	Not Used	
CLM04	N/A	Not Used	
CLM05	R	Not Used	Place of Service Code
CLM05-1	R	11	Facility Type Code: Refer to Code Source 237 for list of HIPAA Accepted Values. 11 = Inpatient hospital; maintained by NUBC.
CLM05-2	R	A	Facility Code Qualifier
CLM05-3	R	1	1=Admit & Discharge Claim 2=Interim 1st Claim 3=Interim Continuing Claim 4=Interim Last Claim 5=Late Charges
CLM06	R	Y	Provider Signature on File Always use "Y" unless DMH instructions indicate otherwise. Need signature on file at County or (direct provider) for authority to bill SDMC.

Element ID	Usage	Valid Values	Comments
CLM07	R	A, C	Medicare Assignment Code A = Assigned. A value of "C" (not assigned) equals "H" (non-Medicare certified provider) in SDMC.
CLM08	R	Y or N	Assignment of Benefit Indicator Always use "Y" unless DMH instructions indicate otherwise.
CLM09	R	Y	Release of Information Code
CLM18	R	Y, N	Explanation of Benefits Indicator Y = paper EOB, N = no paper EOB.

Segment Name		**Discharge Hour**	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		Hospital Inpatient. To be included on the last claim for the encounter. This segment is required on all final inpatient claims.	
Example		DTP*096* TM *2100~	
Element ID	Usage	Valid Values	Comments
DTP01	R	096	Date/Time Qualifier
DTP02	R	TM	Date/Time Format
DTP03	R		Date Time Period

Segment Name		**Statement Dates**	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		Hospital Inpatient claims (mode of service 07, 08, & 09).	
Example		DTP*434* RD8*20031202-20031204~	
Element ID	Usage	Valid Values	Comments
DTP01	R	434	Date/Time Qualifier
DTP02	R	RD8	Date/Time Format D8 = CCYYMMDD, RD8=CCYYMMDD-CCYYMMDD
DTP03	R		Statement from or to Date When using a date range (RD8) the month and year for the "from" and "to" dates must be the same.

Segment Name		**Admission Date/Hour**	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Required on Inpatient Claims	
Segment Notes		Hospital Inpatient claims (mode of service 07, 08, & 09).	
Example		DTP*435*DT*200309152100~	
Element ID	Usage	Valid Values	Comments
DTP01	R	435	Date/Time Qualifier
DTP02	R	DT	Date/Time Format
DTP03	R		Date Time Period

Segment Name		**Institutional Claim Code**	
Segment ID		CL1	
Loop ID		2300	
Segment Usage		Required on Inpatient Claims	
Segment Notes		This segment is used for each Hospital Inpatient claim, Mode of Service = 07, 08, & 09	
Example		CL1*3*1*30~	
Element ID	Usage	Valid Values	Comments
CL101	R	1, 2, 3	Admission Type Code 1 = emergency; 2 = urgent, 3 = elective May be used for ID of emergency service only patients after Phase I.
CL102	R	1	Admission Source Code 1 = Physician Referral
CL103	R	01	Patient Status Code 01 = Discharged to home or self-care.

Segment Name		**Health Care Information Code**	
Segment ID		HI	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This is required on all claims with few exceptions. Do not send decimal points. The actual diagnosis pulled for a specific service will depend on the diagnosis pointer in SV107.	
Example		HI*BK:2956~	
Element ID	Usage	Valid Values	Comments
HI01-01	R	BK	Code List Qualifier Code
HI01-02	R		Industry Standard Code Value according to ICD-9 codes
HI02-01	S		Code List Qualifier Code
HI02-02	S		Industry Standard Code Value according to ICD-9 codes
HI03-01	S		Code List Qualifier Code
HI03-02	S		Industry Standard Code Value according to ICD-9 codes
HI04-01	S		Code List Qualifier Code

Element ID	Usage	Valid Values	Comments
HI04-02	S		Industry Standard Code Value according to ICD-9 codes
HI05-01	S		Code List Qualifier Code
HI05-02	S		Industry Standard Code Value according to ICD-9 codes
HI06-01	S		Code List Qualifier Code
HI06-02	S		Industry Standard Code Value according to ICD-9 codes
HI07-01	R		Code List Qualifier Code
HI07-02	R		Industry Standard Code Value according to ICD-9 codes
HI08-01	R		Code List Qualifier Code
HI08-02	R		Industry Standard Code Value according to ICD-9 codes

Segment Name		**Claim Note**	
Segment ID		NTE	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		Information in the NTE segment in Loop ID-2300 applies to entire claim unless overridden by information in the NTE segment in Loop ID-2400. Although not required, the HFP-IP indicator is needed to perform the alternate crosswalk for HFP-IP Providers in Dual-Use and NPI Mode.	
Example		NTE*UPI*HFP-IP~	
Element ID	Usage	Valid Values	Comments
NTE01	R	UPI	Additional Information
NTE02	R	HFP-IP	Healthy Families Program - Inpatient Provider

Segment Name		**Attending Physician Name**	
Segment ID		NM1	
Loop ID		2310A	
Segment Usage		Required on Inpatient Claims	
Segment Notes		Required on all inpatient claims. Applies to the entire claim unless it is overridden on a service line by the presence of Loop ID 2410 with the same value in NM101. Name of the attending physician.	
Example		NM1*71*1*JONES*JOHN*J***XX*9993700001~	
Element ID	Usage	Valid Values	Comments
NM101	R	71	Entity Identifier Code
NM102	R	1,2	Entity Type Qualifier (1=Person, 2=Non Person)
NM103	R		Attending Physician Last name
NM104	S		Attending Physician First name
NM105	S	Not Used	Attending Physician Middle Name
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R	XX	Identification Code Qualifier XX = NPI.
NM109	R		Attending Provider NPI

Segment Name		**Other Subscriber Information**	
Segment ID		SBR	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Only use for COB situations, including indication of Medicare or Other Health Coverage denial.	
Example		SBR*S*18*351630*Medicare*****MB~	
Element ID	Usage	Valid Values	Comments
SBR01	R	S	Payer Responsibility Sequence Number Code
SBR02	R	18	Individual Responsibility Code
SBR03	S		Insured Group or Policy Number
SBR04	S		Other Insured Group Name
SBR05	N/A	Not used	
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	S	See Table D: Crossover Indicator Crosswalk.	Claim Filing Indicator Code

Segment Name		**Payer Prior Payment**	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Required if claim has been adjudicated by the payer identified in this loop. It is acceptable to show “0” amount paid.	
Example		AMT*C4*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	C4	Amount Qualifier Code
AMT02	R		Other Payer Patient Paid Amount

Segment Name		**Institutional Service Line**	
Segment ID		SV2	
Loop ID		2400	
Usage		Required	
Segment Notes		This segment specifies claim service detail.	
Example		SV2*0100*HC:H2015:HE*838.2*DA*1*838.2~	
Element ID	Usage	Valid Values	Comments
SV201	R		Service Line Revenue Code See Crosswalk
SV202-01	R	HC	Product or Service ID Qualifier
SV202-02	R		HCPCS Procedure Code See Crosswalk
SV202-03	S		HCPCS Modifier 1 See Crosswalk
SV202-04	S		HCPCS Modifier 2 See Crosswalk
SV202-05	S		HCPCS Modifier 3 See Crosswalk
SV202-06	S		HCPCS Modifier 4 See Crosswalk
SV202-07	S	Not Used	
SV203	R		Line Item Charge Amount
SV204	R		Unit or Basis for Measurement Code
SV205	R		Service Line Units
SV206	S		Service Line Rate Amount Required when revenue code (SV201) is 100-219. (should be a daily rate)
SV207	S		Service Line Non-Covered Charge Amount

3.13.1 Example of an 837I Transaction

Interchange Control Header (L_ISA)

ISA*00* *00*
1 *ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*930918*11659*U*00401*000000905*
1*T*:~

Functional Group Header (L_GS)

2 GS*HC*C59*INFOTECHWEBSVCS*20030918*1055*1*X*004010X096A1~

Transaction Set Header (837I)

3 ST*837*10001~

4 BHT*0019*00*4144000001*20030918**CH~

5 REF*87*004010X096A1~

Receiver Name (1000B)

6 NM1*40*2*DMH*****46*INFOTECHWEBSVCS~

Submitter Name (1000A)

7 NM1*41*2*YORK COUNTY HEALTH CARE AGENCY*****46*12345~

8 PER*IC*JANE DOE*TE*9005555555~

Billing/Pay-To Provider Hierarchical Level (2000A)

9 HL*1**20*1~

10 PRV*PT*ZZ*207K00000X~

Billing Provider Name (2010AA)

11 NM1*85*2*YORK COUNTY HEALTH CARE AGENCY*****XX*3301270001~

12 N3*225 MAIN STREET BARKLEY BUILDING~

13 N4*CENTERVILLE*PA*17111~

14 REF*1D*5901~

Subscriber Hierarchical Level (2000B)

15 HL*2*1*22*0~

16 SBR*P*18*******MC~

Subscriber Name (2010BA)

17 NM1*IL*1*DOE*JOHN*T***MI*91234567C~

18 N3*125 CITY AVENUE~

19 N4*CENTERVILLE*PA*17111~

20 DMG*D8*19261111*M~

Payer Name (2010BC)

21 NM1*PR*2*DMH*****PI*01~

Claim information (2300)

22 CLM*90001*1600***11:A:1*Y*A*Y*Y*********N~

23 DTP*435*D8*200309112100~

24 DTP*434*RD8*20030911-20030913

DTP*096*TM*1130

25 CL1*1*1*01~

26 HI*BK:2956~

Attending Physician Name (2310A)

27 NM1*71*1*JONES*JOHN*J***XX*9993700001~

Other Subscriber Information (2320)

28 SBR*P*18*351630*MEDICARE*****MB~

Service Line Number (2400)

29 LX*1~

30 SV2*0100*HC:H2015:HE*1600*DA*2*800~

Subscriber Hierarchical Level (2000B)

31 HL*3*1*22*0~

32 SBR*P*18*******MC~

Subscriber Name (2010BA)

33 NM1*IL*1*DOE*JOHN*T***MI*91234567C~

34 N3*125 CITY AVENUE~

35 N4*CENTERVILLE*PA*17111~

36 DMG*D8*19261111*M~

Payer Name (2010BC)

37 NM1*PR*2*DMH*****PI*01~

Claim information (2300)

38 CLM*90002*800***11:A:1*Y*A*Y*Y*********N~

39 DTP*435*D8*200309020200~

40 DTP*434*D8*20030902~

DTP*096*TM*1400

41 CL1*1*1*01~

42 HI*BK:2956~

Attending Physician Name (2310A)

43 NM1*71*1*JONES*JOHN*J***XX*9993700001~

Other Subscriber Information (2320)

44 SBR*S*01*351630*MEDICARE*****MB~

Other Subscriber Name (2330A)

45 NM1*IL*1*DOE*JANE*S***MI*222004433~

46 N3*125 CITY AVENUE~

47 N4*CENTERVILLE*PA*17111~

Other Payer Name (2330B)

48 NM1*PR*2*STATE TEACHERS*****PI*1135~

Service Line Number (2400)

49 LX*1~

50 SV2*0100*HC:H2015:HE*800*DA*1*800~

Transaction Set Trailer (837I)

51 SE*61*10001~

Functional Group Trailer (L_GS)

52 GE*1*1~

Interchange Control Trailer (L_ISA)

53 IEA*1*000000905~

3.14 SUBMITTING 837 FILES TO DMH

3.14.1 837 File Names and Fiscal Years

1. The production file name must include "P" between County code and 837: DMH_SDM_37_P_837_200403_01.ZIP.
2. The file name must include the month and year of the most recent claim in the file, based on date of service. Counties may add late/retroactive claims from previous months to the current billing month file.

   Example: In April 2006 a County submitted a file with claims for March 2006, February 2006, and December 2005. Since the most recent claim period for this file is March 2006, the date in the file name is _200603_01.TXT.
3. Although an 837 file may contain claims from more than one calendar year, it may not contain claims from more than one fiscal year, based on date of service.

   Example: a claim from May 2005 may not be included with claims from September 2005, as the fiscal year runs from July 1 through June 30.

3.14.2 Preparing the 837 File for Upload

1. Ensure that the 837 HIPAA Transaction has "P" as the Usage Indicator (element ISA15)
2. Ensure that the zip file is encrypted with the right password and that it contains only one text data file with the same name as the zip file.

3.14.3 Uploading the 837 via ITWS

1. Log on to ITWS (https://mhhitws.cahwnet.gov) with your assigned user name and password.
2. From the Systems tab, select Short-Doyle/Medi-Cal – EOB.
3. From the Functions tab, select Upload.
4. Click the Browse or Add button to choose you zip file to upload. Click the Upload button.
5. Select Processing Status Screen from the Functions tab to see the status of your file.
6. From the Functions tab, select Processing Status. This page provides buttons to select and display any errors encountered during validation and translation.

DMH highly recommends using the Re-submit/Cancel function to resubmit corrected files. The following link points you to the ITWS Processing Status, Re-Submit/Cancel Function Users Guide for more information:

https://mhhitws.cahwnet.gov/systems/hipaa/docs/public/chip.asp

Please send a Fax Sheet DMH 1982A along with each file that you upload to ITWS. No action will be taken on your file unless the DMH 1982A is received.

3.15 VOID, CORRECTION, AND REPLACEMENT (VCR) TRANSACTIONS

Void, correction, and replacement(VCR) transactions are submitted in HIPAA-compliant 837 data files via ITWS just as original 837 claims are; i.e., in an electronic interchange envelope by functional group (Professional or Institutional). However, VCR transactions are submitted in

their own 837 file type (the "VCR file"), which may contain any combination of VCR transactions but segregates them from original claims. In this section, "VCR 837" refers to an incoming electronic submission file containing void, correction and replacement transactions only, while "original 837" refers to a file containing original claims only.

As with original claims, DMH generates a 997 Functional Acknowledgment to report the acceptance or rejection of a functional group, transaction set, or segment related to the receipt of an 837P/837I Claim. SD/MC claim processing results for VCR transactions are reported on the 835.

The following definitions apply to VCR transactions.

Void	A transaction submitted to reverse an original approved claim.
Replacement	A transaction submitted to replace a previously voided claim.
Correction	A transaction submitted to correct a previously denied claim.
Target Claim	The original claim targeted by a void, correction, or replacement transaction.
VCR Inception Date	To Be Determined; representing the earliest possible date that counties can be certified.
Certification Date	The specific date relating to when a county has completed the steps necessary for production processing for VCR transactions. Certification dates are unique to each transaction type and each county.
Pre-Adjudication Edits	Edits that are performed prior to SD/MC processing that include file structure conformance, naming convention, valid HIPAA values, 1982A fax, etc.

3.15.1 VCR 837 and 997 Naming Conventions

VCR 837 files are named differently than original 837 files. The table below shows VCR 837 files naming conventions.

Table 13: VCR File Naming Conventions

FILE TYPE	FILE NAMING CONVENTION
837 VCR Zip	DMH_SDM_CC_P_837_VCR_YYYYMM_##.ZIP
837 VCR Text	DMH_SDM_CC_P_837_VCR_YYYYMM_##.TXT
997 VCR Zip	DMH_SDM_CC_P_997_VCR_YYYYMM_##.ZIP
997 VCR Text	DMH_SDM_CC_P_997_VCR_YYYYMM_##.TXT

Notes:
= Sequential number for same month of service; e.g. "01-99"
CC = County Code
P = Production file; note that a "T" in this position indicates a Test (certification) file
CR = Replacement/Correction file
VCR = Void/Correction/Replacement file
Zip = Compressed

3.15.2 Use of the Unique ID

Like original claims, all VCR transactions must contain a Unique ID. Please see previous section titled 'Use of a Service Line Unique Identifier' for more information.

3.15.3 Processing Requirements

The table below provides processing requirements applying to all three transaction types. These requirements are in addition *to* existing processing requirements for original claims.

Table 14: Processing Requirements

REQUIREMENT	NOTES
1. VCR transactions may only be submitted after VCR inception.	If a County submits a VCR transaction prior to VCR inception, a fatal error is raised and the 837 file is rejected.
2. DMH will accept VCR transactions only after County Certification Date.	DMH will ensure that a County submits only transactions of a type (void, correction, or replace) for which they have been certified. If a County submits a VCR file containing transaction types for which they have not yet been certified, the entire file will be rejected.
3. VCR transaction types can be submitted in one 837 file.	DMH will accept VCR transactions together in a VCR 837 file, which cannot contain original claims.
4. For all VCR transactions, one service line per claim will be enforced for both the 837P and the 837I.	The Claim Frequency Type field (which determines whether the transaction is a void, a correction, or a replacement) and the Original Reference Number field (which targets the original claim) are both required for these transactions. Both fields are contained in the 2300 loop.

3.15.4 Certification

The table below describes the steps required for VCR certification.

Table 15: Certification Steps

Step 1	**Ensure your County is HIPAA certified** before beginning certification for voids, replacements, and corrections.
Step 2	**Create test transaction files.** Create a file of original claims and a minimum of three test VCR files according to the guidelines specified in section titled 'Requirements for Test Files.'
Step 3	**Obtain access to ITWS testing area.** Access will NOT be available until you have received authorization via email (allow 3–5 working days). Questions may be directed to the ITWS Helpdesk at https://mhhitws.cahwnet.gov/docs/public/contact.asp.
Step 4	**Zip and name your test data.** The password for zipping the file is the same as the one used currently in the production environment. Each claim file must be compressed and encrypted using PKZip® version 6.0.147 or WinZip® version 8.0 (or above). Each zip file may contain only one claim file. For test files, use these file name conventions (for a complete list of new VCR file name conventions for Production, see section 3.15.1). The compressed 837 claim file name must be in this format: DMH_SDM_CC_T_837_VCR_YYYYMM_##.ZIP The text 837 claim file name must be in this format: DMH_SDM_CC_T_837_VCR_YYYYMM_##.TXT ---------- CC: County Code T: Test file VCR: Void/Correction/Replacement claim file YYYYMM: Year and Month ##: Sequential Number for same month of service, "01-99"
Step 5	**Upload test data to ITWS.** (See the ITWS Virtual Tour for upload instructions.)
Step 6	**HIPAA validation (Claredi) edits**. All test files must meet WEDI / SNIP Types 1–5 testing requirements. When an 837 file (either P or I) is successfully uploaded via ITWS, HIPAA validation using Claredi is performed. The 997 Functional Acknowledgement provides file status. The County receives an email message when the 997 is available. Errors must be corrected; the test file is then resubmitted using the ITWS Processing Status screen, which provides error description details (click on the HIPAA Error Details button).
Step 7	**Pass translator validation edits.** The 837 file must pass translator edits before the SD/MC file for adjudication is created. All translator errors must be corrected before the file is resubmitted via the ITWS Processing Status screen. The SD/MC file is then created, a batch number is assigned, and the file is sent to SD/MC for processing. The submitting County will receive an email notice when the claim file has been successfully validated by the translator.

Step 8	**Review the 835.** DMH reviews the 835 with the County to evaluate the adjudicated test claim files.
Step 9	**Accept certification test results.** The County sends an email confirmation of acceptance of certification test results to HIPAA-TCS@dmh.ca.gov. The acceptance must be sent by County staff rather than a vendor.
Step 10	**County receives a VCR certification email**. When certification has been successfully completed and DMH approves your results, DMH will send a confirmation email that the County is certified for the particular transaction type (void, correction, or replace). The County is now ready to begin submitting claims of that type.

3.15.5 Requirements for Test Files

To successfully test and certify for submitting VCR transactions, the County must:

1. Submit one file of original claims that will serve as the pool of "target" claims for processing of VCR transactions.
2. Submit a minimum of three test VCR 837 files; each file must contain at least 100 records.

The County is then ready for transaction testing. The objective is to achieve 100 "successful" transactions per type. Successful transactions are defined as those that pass all pre-adjudication edits and for which 835 files have been generated. The County must meet these goals:

1. 100 successful correction transactions
2. 100 successful replacement transactions
3. 100 successful void transactions AND 80% of the voids in the last file must be approved

File submission requirements and certification criteria are summarized in the table below.

Certification for one transaction type fulfills the 3-file requirement for the remaining two types; i.e., if a County has been certified for corrections, it has met the 3-file criterion for voids and replacements as well.

For the purposes of this void scenario, assume that the County has been previously certified for correction transactions as in the scenario above.

Assume the County has already submitted one 837 file of original claims. Now the County must meet criteria A and B.

A: Submit a minimum of three VCR 837 files with at least 100 records per file.

B: Achieve at least 100 successful correction transactions.

STEP	DESCRIPTION	CRITERIA MET?	
		A	B
1	County submits two VCR 837 files, achieves 45 successful corrections.	N	N
2	County submits another VCR 837 file for a total of 3 files of 100 records each; successful corrections now total 95.	Y	N

3	Although the 3-file requirement has been met, County submits another VCR 837 test file of 100 records to fulfill criterion B. The total of successful corrections increases to 110. The County is now certified for correction transactions.	Y	Y

3.15.6 Void Certification Scenario

Assume the County has already submitted an 837 file of original claims and 3 test files as in the correction scenario above. For the purposes of this void scenario, assume that the County has been previously certified for correction transactions as in the scenario above. Criterion A below has been met; now the County must meet B and C.

A: Submit a minimum of three VCR 837 files with at least 100 records per file.

B: Achieve at least 100 successful void transactions.

C: Achieve an 80% void approval rate in the last file.

STEP	DESCRIPTION	CRITERIA MET?		
		A	B	C
1	When the County submitted 3 VCR files for corrections certification, there were 98 successful voids (criterion B not yet met). 100% of voids in the third submitted file were approved, but since it will not be the last file, criterion C has not yet been met.	Y	N	N
2	County submits a fourth VCR 837 test file of 100 records. The total of successful voids reaches 225. However, only 65% of the void transactions submitted in the last file were approved.	Y	Y	N
3	County submits another (fifth) file to meet criterion C. 100% of the void transactions in this last file are approved. The County is now certified for void transactions.	Y	Y	Y

3.15.7 Replacement Certification Scenario

Reminder: A County must be certified for void transactions before it can be certified for replacements, since replacements may only be submitted for previously successfully voided claims.

Assume the County has already submitted a test 837 file of original claims and 5 test files for voids as in the preceding scenario. Criterion A has been met; now the County must meet criterion B:

A: Submit a minimum of three VCR 837 files with at least 100 records per file.

B: Achieve at least 100 successful replacement transactions

STEP	DESCRIPTION	CRITERIA MET?	
		A	B
1	The 5 VCR files submitted in the void certification process included 98 successful replacement transactions.	Y	N

2	County submits another VCR 837 file to attain 100 successful replacement transactions. This file brings the total of successful replacement transactions to 134. County is now certified for replacement transactions.	Y	Y

3.15.8 Segment and Data Element Descriptions

The following table identifies the elements for VCR claims that are different from original claims; i.e., CLM01, CLM05-3, and REF02. Elements not shown remain the same.

837P

Segment Name	**Claim Information**
Segment ID	CLM
Loop ID	2300
Segment Usage	Required
Segment Notes	This loop should be subordinate to Loop 2000B for SD/MC.
Example	CLM*90001*826.78***11:A:1*Y*A*Y*Y*********N~

Data Element (DE) Information

DE ID	DE No.	DE Name	Usage	Comments
CLM05-3	1325	Claim Frequency Type Code For 837P, alias = Claim Submission Reason Code	R	Permissible code values for this sub-element: 1 - Original claim AND - Original Reference Number blank (new claim) 1 - Original claim AND - Original Reference Number populated (correction of previously denied claim) 7 - Replacement of a previously voided claim 8 - Void of a previously approved claim
REF02	127	Original Reference Number	R	The Unique ID of the original claim, required when CLM05-3 (Claim Frequency Type Code) is 1 (correction only), 7, or 8.

837P

Segment Name	**Claim Information**
Segment ID	REF
Loop ID	2400
Segment Usage	Required
Segment Notes	This loop should be subordinate to Loop 2000B for SD/MC.
Example	REF*6R*31063

Data Element (DE) Information

DE ID	DE	DE Name	Usage	Comments

	No.			
REF02	R	Line Item Control Number	R	The Unique ID of the claim; for more information see section 3.6.

837I

Segment Name	**Claim Information**			
Segment ID	CLM			
Loop ID	2300			
Segment Usage	Required			
Segment Notes	This loop should be subordinate to Loop 2000B for SD/MC.			
Example	CLM*90001*826.78***11:A:1*Y*A*Y*Y*********N~			
Data Element (DE) Information				
DE ID	DE No.	DE Name	Usage	Comments
CLM01	1028	Claim Submitter's Identifier (Industry: Patient Account Number)	R	The Unique ID of the claim; for more information see section 3.6.
CLM05-3	1325	Claim Frequency Type Code For 837P, alias = Claim Submission Reason Code	R	Permissible code values for this sub-element: 1 - Original claim AND - Original Reference Number blank (new claim) 1 - Original claim AND - Original Reference Number populated (correction of previously denied claim) 7 - Replacement of a previously voided claim 8 - Void of a previously approved claim
REF02	127	Original Reference Number	R	This number is the Unique ID of the original claim, required when CLM05-3 (Claim Frequency Type Code) is 1 (correction only), 7, or 8.

3.15.9 Void Transactions

A void transaction allows Counties to void an original approved claim. DMH matches the Original Reference Number (REF02) of the void transaction with the unique ID of the original claim to be voided.

The void transaction reported on the 835 mirrors the original approved claim with the exception of all dollar, units of time, and units of service fields. These fields will be the negative of the original approved claim. The only exception to this rule is the Maximum Allowed Amount, which will remain positive.

Follow these rules when submitting void transactions:

1. Void transactions can be submitted only for original claims received after VCR inception.
2. A claim may be voided up to 18 months after the month of service.
3. Void transactions must be submitted with a Claim Frequency Type Code of 8.
4. The Unique ID of the target claim must be submitted in the Original Reference Number field of the void transaction.
5. An original claim can be successfully voided only once.

3.15.10 Replacement Transactions

A replacement transaction allows Counties to replace a previously voided claim while retaining the received date of the original claim. DMH matches the Original Reference Number (REF02) of the replacement transaction with the Unique ID of the original claim to be replaced. All replacement transactions will be reported on the 835.

Follow these rules when submitting replacement transactions:

1. A replacement transaction may be submitted only after VCR inception.
2. Replacement transactions can be submitted only for original claims received after VCR inception.
3. A claim may be replaced up to 18 months after the month of service.
4. A replacement transaction can be submitted only if a void transaction has been previously submitted for the original claim.
5. Replacement transactions must be submitted with a Claim Frequency Type code of 7.
6. The unique ID of the previously voided claim must be submitted in the Original Reference Number field of the replacement transaction.
7. An original voided claim can be replaced only once.

3.15.11 Correction Transactions

A correction transaction allows Counties to correct a previously denied claim while retaining the received date of the original claim. DMH matches the Original Reference Number (REF02) of the replacement transaction with the Unique ID of the original claim to be replaced. All correction transactions will be reported on the 835. A claim may be corrected under the following conditions:

1. The original transaction was received within 6 months after the month of service **without** a delay reason code (late billing code), **or**
2. The original transaction was received within 12 months after the month of service **with** a delay reason code (late billing code).

If the claim was denied due to late billing, a new original transaction should be submitted with the delay reason code—not a correction transaction. The correction process does not change any requirement for timely billing.

Follow these rules when submitting replacement transactions:

1. Original claims received after VCR inception can be corrected.
2. A claim may be corrected up to 18 months after the month of service.
3. Correction transactions must be submitted with a Claim Frequency Type code of 1. Additionally, the Unique ID of the previously denied claim must be submitted in the Original Reference Number field of the correction transaction.

4. An original denied claim can be corrected only once.

3.15.12 Error Codes

If void transactions are denied by SD/MC, an error code will be provided on the 835. Table I, Transaction Code Denial Reason Error Code Crosswalk, relates SD/MC error codes to HIPAA Adjustment Reason and Remark Codes. Part B shows the crosswalk specific to void errors.

If an error occurs at the translator, the ITWS Processing Status Webpage will identify the error as shown in Table M, Translator Errors (837) List.

3.15.13 Processing Scenarios for VCR Transactions

This section provides scenarios to illustrate what action to take in response to void, correction and replacement processing issues. Table 16 provides column definitions for the scenarios.

Table 16: Scenario Column Definitions

	HEADING	DESCRIPTION
1	Sequence Number	Number assigned to each transaction in the scenario indicating sequence of events.
2	Transaction Type	Identifies the transaction as an original, void, correction, or replacement.
3	Received Date	The claim received date at DMH via ITWS.
4	Calculated Received Date	The date the target claim was received at DMH. This feature, pertaining only to replacement and correction transactions, allows claims to preserve the original claim's received date.
5	ID	The Unique ID of claim simplified in the scenarios below (i.e., the ID shown does not conform to correct Unique Claim ID format).
6	ORN	The Original Reference Number is the Unique Claim ID of the target claim. Every void, correction, or replacement transaction is matched to its target using the ORN.
7	Processing Result	The status assigned to the transaction that sets the stage for the action the county must take next. To build the scenarios, the status is important for the next step, not the reason for the status; therefore, no reasons for denied claims are included.
8	Necessary County Action	The next step to reach the status indicated in the scenario title, given the claim information provided in columns 1–7.
9	Notes	Clarification of a transaction step as required.

3.15.14 Correction Transaction Scenarios

These scenarios assume a VCR inception date of January 31, 2007. The Original Reference Number (ORN) is the Unique ID of the claim targeted by the transaction. The format shown for the Unique ID/ORN illustrates their interrelationship within the scenario.

Scenario 1 - Original Denied, Correction Approved

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Denied by SD/MC.	None.	
2	Correction	3/1/2007	2/1/2007	AB	A	Approved by SD/MC.	None.	

Scenario 2 - Original Approved, Correction Denied

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC.	None.	
2	Correction	3/1/2007	2/1/2007	AB	A	Denied by SD/MC.	None.	Only previously denied claims can be corrected.

Scenario 3 – Void Transaction is Denied

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	County wants to void claim.
2	Void	3/1/2007	2/1/2007	AB	A	Denied by SD/MC	None.	
3	Correction	4/1/2007	2/1/2007	ABC	AB	Denied by Translator	Submit another void claim.	Only denied original and denied replacement claims can be corrected.
4	Void	5/1/2007	4/1/2007	ABCD	A	Approved by SD/MC	None.	

Scenario 4 – Correct a Replacement Transaction

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	County wants to void and replace the claim.
2	Void	3/1/2007	2/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Denied by SD/MC	None.	
4	Correction	5/1/2007	2/1/2007	ABCD	A	Denied by SD/MC	Submit new correction targeting the denied replacement.	A correction must target a denied claim (here, the replacement; the original—ORN “A”—was approved).

Scenario 5 - Correction Error at Translator

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	12/2/2006	12/2/2006	A		Denied by SD/MC	None.	
2	Correction	3/1/2007	ERROR	AB	A	Denied by Translator	None.	Entire inbound 837 rejected. Correction targets original claim received prior to VCR inception.

Scenario 6 – Multiple Correction Errors

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Denied by SD/MC	None.	
2	Correction	3/1/2007	2/1/2007	AB	A	Denied by SD/MC	Submit another correction.	
3	Correction	3/5/2007	2/1/2007	ABC	A	Denied by Translator	Submit another correction targeting the first correction (ID: AB)	Entire inbound 837 file is rejected. A claim can only be corrected once.
4	Correction	4/1/2007	2/1/2007	ABCD	AB	Approved by SD/MC	None.	

Scenario 7 – Correct an Approved Claim

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Correction	3/1/2007	2/1/2007	AB	A	Denied by SD/MC	None.	Only previously denied claims can be corrected.
3	Void	4/1/2007	2/1/2007	ABC	A	Approved by SD/MC	None.	
4	Replacement	5/1/2007	2/1/2007	ABCD	A	Approved by SD/MC	None.	

Scenario 8 – Correction Received Too Late

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Denied by SD/MC	None.	Date of Service for is equal to 1/1/2007
2	Correction	7/1/2008	2/1/2007	AB	A	Denied by SD/MC	None.	Correction received more than 18 month after date of service of target claim.

3.15.15 Void and Replacement Transaction Scenarios

Scenario 1 - Original Approved, Void Approved

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	

Scenario 2 - Void Errors at Translator

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	A	A	Error at Translator	Submit new void transaction with corrected error.	Entire inbound 837 is rejected due to duplicate unique ID error.
3	Void	4/1/2007	4/1/2007	AB	A	Approved by SD/MC	None.	

Scenario 3 - Void Errors at SD/MC

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	12/2/2006	12/2/2006	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Denied by SD/MC	None.	Original claim received prior to VCR inception and cannot be voided.

Scenario 4 - Original Denied, Void Error at SD/MC

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Denied by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Denied by SD/MC	None.	Only approved claims can be voided.

Scenario 5 - Replacement Erroneously Targets Void

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	AB	Denied by Translator	Submit new replacement.	Entire inbound 837 file is rejected. Replacement must target original voided claim.
4	Replacement	5/1/2007	2/1/2007	ABCD	A	Approved by SD/MC	None.	

Scenario 6 - Replacement Targets Previously Replaced Claim

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Approved by SD/MC	None.	
4	Replacement	5/1/2007	2/1/2007	ABCD	A	Denied by SD/MC	Void the first replacement claim (unique ID - ABC) then resubmit the replacement claim.	An original claim can only be replaced once.

Scenario 7 - Void Targets Previously Voided Approved Claim

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Approved by SD/MC	None.	
4	Void	5/1/2007	5/1/2007	ABCD	A	Denied by SD/MC	If replacement should be voided, submit new void transaction with replacement (unique ID - ABC) as target.	An original claim can only be voided once.

Scenario 8 - Void Targets Replacement

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Approved by SD/MC	None.	
4	Void	5/1/2007	5/1/2007	ABCD	ABC	Approved by SD/MC	None.	

Scenario 9 - Replacement for Denied Void

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Denied by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Denied by SD/MC	Submit new void that approves, and then submit another replacement transaction.	Only voided claims can be replaced.

Scenario 10 - Replacement for Denied Void

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Denied by SD/MC	None.	
3	Replacement	4/1/2007	2/1/2007	ABC	A	Approved by SD/MC	County can void either original or replacement claim.	

Scenario 11 - Void Cannot Find Target Claim

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	BC	Denied by Translator	Submit another void transaction with valid target claim ORN.	Entire inbound 837 file is rejected

Scenario 12 - Replacement Cannot Find Target Claim

SEQ #	TX TYPE	RECEIVED DATE	CALCULATED RECEIVED DATE	ID	ORN	PROCESSING RESULT	NECESSARY COUNTY ACTION	NOTES
1	Original	2/1/2007	2/1/2007	A		Approved by SD/MC	None.	
2	Void	3/1/2007	3/1/2007	AB	A	Approved by SD/MC	None.	
3	Replacement	4/1/2007	ERROR	ABC	BC	Denied by Translator	Submit another replacement with a valid target claim.	Entire inbound 837 file is rejected
4	Replacement	5/1/2007	2/1/2007	ABCD	A	Approved by SD/MC	None.	

4 997 FUNCTIONAL ACKNOWLEDGEMENT

DMH validates incoming 837 transactions by first checking the syntax of the transaction for X12 compliance and then validating the data against HIPAA implementation guidelines using Claredi. A 997 Functional Acknowledgment is then generated to report the acceptance or rejection of a functional group, transaction set, or segment related to the receipt of the 837P/I claim. If a transaction contains errors, the entire file is rejected.

4.1 THE TA1 INTERCHANGE ACKNOWLEDGEMENT

TA1, also known as an Interchange Acknowledgment, is a segment that occurs within a 997 Functional Acknowledgement. Whenever a TA1 is present, the acknowledgement is itself called a TA1 rather than a 997. The presence of TA1 means that there is an error in the Interchange Control Envelope of the transaction. More specifically, it indicates an error in the ISA (header) or IEA (trailer) segments of the original transaction.

4.2 EXAMPLES OF 997 MESSAGES FOR ACCEPTED/REJECTED TRANSACTION SETS

Scenario 1: Accepted Transaction Set

The following message shows a 997 for an accepted functional group with only one transaction set.

```
ISA*00*                                                    *00*
*ZZ*INFOTECHWEBSVCS*ZZ*C19000000000000*030922*1945*U*00401*000000306*0*
P*:
GS*FA*INFOTECHWEBSVCS*C19000000000000*20030922*1945*297*X*004010X098A1
ST*997*0295
AK1*HC*0
AK2*837*0001
AK5*A              -- A indicates an Accepted Transaction Set
AK9*A*1*1*1        -- A indicates an Accepted Functional Group
SE*6*0295
GE*1*297
IEA*1*000000306
```

Scenario 2: Rejected Transaction Set

The following shows a 997 for a rejected functional group with only one transaction set.

```
ISA*00*          *00*
*ZZ*INFOTECHWEBSVCS*ZZ*C08000000000000*061206*0956*U*00401*000000284*0*
T*:
GS*FA*INFOTECHWEBSVCS*C08000000000000*20061206*0956*263*X*004010X098A1
ST*997*0151
AK1*HC*1
AK2*837*0001
```

AK3*__HI__*__3115__*__2300__*8 -- HI Segment at line 3115, loop 2300 has an error
AK4*__3:2__*1271*7*__V612__ -- Position 3:2, V612 is the erroneous data element

AK3*__SBR__*__5963__*__2320__*8 -- SBR Segment at line 5963, loop 2320 has an error
AK4*__2__*1069*7*__34__ -- Position 2, 34 is the erroneous data element

AK5*R*5
AK2*837*0002
AK5*A
AK9*P*2*2*1
SE*26*0151
GE*1*263
IEA*1*000000284

Scenario 3: TA1 Rejected Transaction Set

ISA*00* *00*
*ZZ*INFOTECHWEBSVCS*ZZ*C19000000000000*040112*1142*U*00401*000000252*0*
T*:~
__TA1__*000000126*040109*1305*R*__006__~
IEA*0*000000252~

5 835 HEALTH CARE CLAIM PAYMENT/ADVICE

5.1 DOWNLOADING THE 835 VIA ITWS

Log into ITWS. From the Systems menu, select the Short-Doyle/Medi-Cal Claims - EOB system. (See the ITWS Virtual Tour for download instructions.)

5.2 SERVICE LINE ADJUSTMENTS AND DENIALS

A CAS segment is created when a service line is denied or adjusted. Service line adjustment and denial reasons are contained in Table I and Table J.

1. If there are multiple errors for a service line, the denied amount will only be reported on the first CAS segment.
2. If a County submits service line adjustments (SVD segments on the 837), the adjustment amounts are rolled up and reported as a single adjustment on one CAS segment with Adjustment Group Code equal to 'OA'.

5.3 ISA-IEA SEGMENTS

This section describes DMH's use of the interchange control segments. It includes a description of expected sender and receiver codes and delimiters.

Segment Name		**Interchange Control Header**	
Segment ID		ISA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		All positions within each data element in the ISA segment must be filled. Delimiters are specified in the Interchange Header Segment. The values are as follows: * Asterisk Data Element Separator : Colon Sub element Separator ~ Tilde Segment Terminator	
Example		ISA*00* *00* *ZZ*INFOTECHWEBSVCS*ZZ*C590000000000 0*030930*1256*U*00401*000000636*0*P*:~	
Element id	Usage	Valid values	Comments
ISA01	R	00	Authorization Information Qualifier
ISA02	R	*10 Blanks*	Authorization Information; Fixed Length
ISA03	R	00	Security Information Qualifier
ISA04	R	*10 Blanks*	Security Information:
ISA05	R	ZZ	Interchange ID Qualifier
ISA06	R	INFOTECHWEBSV CS	
ISA07	R	ZZ	Interchange ID Qualifier;

ISA08	R		For County: C + County Code + 12 Zeroes, Examples: C59000000000000
ISA09	R		Interchange Date; the date format is YYMMDD The date on which 835 is created
ISA10	R		Interchange Time; the time format is HHMM The time at which 835 is created
ISA11	R	U	Interchange Control Standards Identifier
ISA12	R	00401	Interchange Control Version Number
ISA13	R		Running serial number for each County
ISA14	R	0	Acknowledgment Requested; If value were 1 = Interchange Acknowledgment (TAI01); Not currently supported 0 – No Interchange Acknowledgment Requested
ISA15	R		Usage Indicator: T for Test P for Production
ISA16	R	:	Component Element Separator: The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.

Segment Name		**Interchange Control Trailer**	
Segment ID		IEA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		IEA*1*000000636~	
Element ID	Usage	Valid Values	Comments
IEA01	R	1	Number of included functional groups; Number of functional groups included in this interchange envelope
IEA02	R		Authorization Information same as ISA13

5.4 GS-GE SEGMENTS

This section describes the DMH use of the functional group control segments and the expected sender and receiver codes. There can be one GS-GE segments in one ISA-IEA segment.

Segment Name		**Functional Group Header**	
Segment ID		GS	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		Indicates the beginning of a functional group and to provide control information.	
Example		GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A1~	
Element ID	Usage	Valid Values	Comments
GS01	R	HP	Functional Identifier Code
GS02	R	INFOTECHWEBSVCS	
GS03	R	For County: C + County Code + 12 Zeroes, Examples: C59000000000000	Application Receivers Code
GS04	R		Date - CCYYMMDD
GS05	R		Time - HHMMSS
GS06	R		Group Control Number
GS07	R	X	Responsible Agency Code
GS08	R	004010X091A1	Version identifier code

Segment Name		**Functional Group Trailer**	
Segment ID		GE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		GE*5*614~	
Element ID	Usage	Valid Values	Comments
GE01	R		Number of Transaction Sets Included
GE02	R		Group Control Number same as GS06

5.4.1 Sample Interchange Control

ISA*00* *00* *ZZ*INFOTECHWEBSVCS*ZZ*C59000000000000*030930*1256
*U*00401*000000636*0*P*:~
GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A
1~
ST – 835 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 835 TRANSACTION SET TRAILER
ST – 835 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 835 TRANSACTION SET TRAILER
GE*5*614~
IEA*1*000000636~

5.5 SEGMENT USAGE

The following matrix lists only those segments used by DMH in creating the 835. This implementation guide identifies all required segments for 835 transactions. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Table 17: Segment Usage – 835

SEGMENT ID	LOOP ID	SEGMENT NAME	R=REQUIRED / S=SITUATIONAL
ST	N/A	Transaction Set Header	R
BPR	N/A	Financial Information	R
TRN	N/A	Reassociation Trace Number	R
REF	N/A	Receiver Identification	R
DTM	N/A	Production Date	R
N1	1000A	Payer Identification	R
N3	1000A	Payer Address	R
N4	1000A	Payer City, State, Zip Code	R
N1	1000B	Payee Identification	R
LX	2000	Header Number	R
CLP	2100	Claim Level Data	R
NM1	2100	Patient Name	R
NM1	2100	Corrected Patient Insured Name	R
NM1	2100	Service Provider Name	R
NM1	2100	Corrected Priority Provider Name	R
REF	2100	Other Claim Related Information	R
REF	2100	Other Claim Related Information	R
REF	2100	Other Claim Related Information	R
DTM	2100	Claim Date	R
AMT	2100	Claim Supplemental Information	S
SVC	2110	Service Payment Information	R
DTM	2110	Service Date	R
CAS	2110	Service Adjustment	S
REF	2110	Service Identification	R
REF	2110	Rendering Provider Information	S
AMT	2110	Service Supplemental Quantity	S
LQ	2110	Health Care Remark Codes	S
PLB	N/A	Provider Adjustment	S
SE	N/A	Transaction Set Trailer	R

5.6 SEGMENT AND DATA ELEMENT DESCRIPTION

This section contains a tabular representation of any segment required or situational for the DMH HIPAA implementation of the 835.

Segment Name		**Transaction Set Header**	
Segment ID		ST	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment begins the transaction.	
Example		ST*835*0001~	
Element ID	Usage	Valid Values	Comments
ST01	R	835	Transaction Set Identifier Code
ST02	R	0001	Transaction Set Control Number

Segment Name		**Financial Information**	
Segment ID		BPR	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment is used to address a single payment to a single payee; The usage of this segment by DMH is only as a notification. No remittance information is included.	
Example		BPR*H*0*C*NON**********20031001~	
Element ID	Segment Usage	Valid Values	Comments
BPR01	R	H	835 transaction handling code is always (H) - notification only.
BPR02	R	0	835 transactions are notification only; this value is always zero.
BPR03	R	C	Credit / Debit Flag Code
BPR04	R	NON	Because BPR01 = H, NON (Non-Payment Data) is used here.
BPR16	R		Date of 835. CCYYMMDD format.

Segment Name		**Reassociation Trace Number**	
Segment ID		TRN	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment uniquely identifies a transaction to an application	
Example		TRN*1*592003061003*1482003030*DMH~	
Element ID	Usage	Valid Values	Comments
TRN01	R	1	Trace Type Code
TRN02	R		Check or EFT Trace Number. SD/MC batch number is placed here.
TRN03	R	1680309373	Payer Identifier Federal Tax ID, preceded by "1"; if BPR10 is used, they must match.
TRN04	R	DMH	Used to identify the payer.

Segment Name		**Receiver Identification**	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the receiver.	
Example		REF*EV*59~	
Element ID	Usage	Valid Values	Comments
REF01	R	EV	Reference Identification Qualifier
REF02	R		Receiver ID (County Code) from loop 1000A, NM109 in the 837 Transaction

Segment Name		**Production Date**	
Segment ID		DTM	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment provides claim date information.	
Example		DTM*405*20030820~	
Element ID	Usage	Valid Values	Comments
DTM01	R	405	Reference Identification Number;
DTM02	R		This is the date SD/MC processed the claims on this 835. Approved and denied claims use the SD/MC system cutoff date. Suspended claims use the systems run date (also known as Adjudication Date). The format is CCYYMMDD.

Segment Name		**Payer Identification**	
Segment ID		N1	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This segment identifies a party by type of organization, name, and code	
Example		N1*PR*01~	
Element ID	Usage	Valid Values	Comments
N101	R	PR	Entity Identifier Code
N102	S	01	Payer Name; Valid Value: 01 – DMH
N103	N/A	Not used	Identification Code Qualifier
N104	N/A	Not used	Identification Code

Segment Name		**Payer Address**	
Segment ID		N3	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This segment conveys Street Address information	
Example		N3*1600 9th STREET~	
Element ID	Usage	Valid Values	Comments
N301	R	1600 9th STREET	Billing Provider Address Information
N302	S		Required if Second Address Line exists

Segment Name		**Payer City/State/Zip**	
Segment ID		N4	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		Payer City/State/ZIP	
Example		N4*SACRAMENTO*CA*95814~	
Element ID	Usage	Valid Values	Comments
N401	R	Sacramento	City Name
N402	R	CA	State or Province Code
N403	R	95814	Postal Code

Segment Name		**Payee Identification**	
Segment ID		N1	
Loop ID		1000B	
Segment Usage		Required	
Segment Notes		This segment identifies the Payee in the transaction.	
Example		N1*PE*York County Care Agency*FI*956000928~	
Element ID	Usage	Valid Values	Comments
N101	R	PE	Entity Identifier Code
N102	R		Payee Name; Same as Pay-To Provider Name from the 837. If the Pay-To Provider Loop was not sent, this will be the Billing Provider Name.
N103	R	FI or XX	FI = EIN XX = NPI
N104	R		Payee Identification Code; This is the Pay-To Provider ID from the 837. If the Pay-To Provider Loop was not sent, this will be the Billing Provider ID. It will be either an EIN or an NPI.

Segment Name		**Payee Additional Identification**	
Segment ID		REF	
Loop ID		1000B	
Segment Usage		Situational	
Segment Notes		If the Primary Payee identifier (Loop 1000B, N1) is an NPI, then the EIN (if provided on the 837) appears here.	
Example		REF*TJ*123456789~	
Element ID	Usage	Valid Values	Comments
REF01	R	TJ	Reference Identification Qualifier: TJ = EIN
REF02	R		Reference Identification; EIN
REF03	N/A	Not used	Description
REF04	N/A	Not used	Reference Identifier

Segment Name		**Header Number**	
Segment ID		LX	
Loop ID		2000	
Segment Usage		Required	
Segment Notes			
Example		LX*1~	
Element ID	Usage	Valid Values	Comments
LX01	R		Assigned Number

Segment Name		**Claim Payment Information**	
Segment ID		CLP	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment supplies information common to all services of a claim.	
Example		CLP*1887*4*562*0**MC~	
Element ID	Usage	Valid Values	Comments
CLP01	R		Claim Submitter's Identifier This is the patient account number (Loop 2300, CLM01) from the 837I and 837P.
CLP02	R		Claim Status Code; 4 = Denied, 13 = Suspended, 25 = Predetermination Pricing Only - No Payment. See crosswalk: Table G - Mapping the SD/MC EOB Codes to the 835
CLP03	R		Total Claim Charge Amount: Taken from Loop 2300, CLM02 in 837 Transaction.
CLP04	R		Claim Payment Amount. This is the amount paid for all services on the claim.
CLP05	N/A		Patient Responsibility Amount; This will not be used to report Patient Share of Cost. Share of Cost will be reported in the Claim Supplemental Information segment.
CLP06	R	MC	MC = MEDICAID
CLP07	N/A		Payer Claim Control Number; Not Used
CLP08	S		Only used if adjudication changed the value from what was originally sent on the claim
CLP09	S		This is the value from CLM05-3 on the 837.

Segment Name		**Patient Name**	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies the Patient associated with a claim.	
Example		NM1*QC*1*JONES*JOHN*J***HN*1234567890~	
Element ID	Usage	Valid Values	Comments
NM101	R	QC	Entity Identifier Code, QC=Patient
NM102	R	1	Entity Type Qualifier, 1 – Person
NM103	R		Patient Last Name
NM104	R		Patient First Name
NM105	S		Patient Middle Name/Initial
NM106	N/A		CLAIM FILING INDICATOR CODE
NM107	N/A		Name Suffix
NM108	S	HN	Identification Code Qualifier; HN= Health Insurance Claim Number
NM109	S		Patient Identifier (CIN, BIC, etc.) submitted in Loop 2010BA Element NM109 of the 837.

Segment Name		**Corrected Patient / Insured Name**	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		Corrected patient information for Medicaid.	
Example		NM1*74*1******C*592091002839A~	
Element ID	Usage	Valid Values	Comments
NM101	R	74	Entity Identifier Code 74=Corrected Insured
NM102	R	1	Entity Type Qualifier 1 - Person 2 - Nonperson
NM103	R		Patient Last Name or Organization Name
NM104	R		Patient First Name
NM105	S		Patient Middle Name
NM106	N/A		Name Prefix (Not Used)
NM107	N/A		Name Suffix Not Used
NM108	R	C	Identification Code Qualifier; C = Insured's Changed Unique ID Number
NM109	R		Identification Code: County Code, approved Aid Code, and CIN from SD/MC, in that order.

Segment Name		**Service Provider Name**	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies the Service Facility Location at the claim level and is required when the Service Facility Location is different from the Payee, which is true in most cases for SD/MC.	
Example		NM1*82*2******MC*5905~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code 82=Rendering Provider
NM102	R	2	Entity Type Qualifier 2 –Non person
NM103	N/A		Rendering Provider Last Name or Organization Name;
NM104	N/A		Rendering Provider First Name;
NM105	N/A		Rendering Provider Middle Name:
NM106	N/A		Name Prefix;
NM107	N/A		Name Suffix;
NM108	R	MC or XX	Identification Code Qualifier; MC = SD/MC Provider Number XX = NPI
NM109	R		This is the Service Facility Location identifier submitted at the claim level on the 837.

Segment Name		**Corrected Priority Payer Name**	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies a third party payer.	
Example		NM1*PR*2*Medicare Part A and Part B*****PI*Z~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR	PR = Payer
NM102	R	2	Entity Type Qualifier 1 – Person 2 –Non person
NM103	S		See TPL crosswalk for details – name of organization.
NM104	N/A		First Name
NM105	N/A		Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI	PI = Payer Identification
NM109	R		Corrected Priority Payer ID See TPL crosswalk for details

Segment Name		**Other Claim Related Information**	
Segment ID		REF	
Loop ID		2100	
Segment Usage		Situational	
Segment Notes		Additional patient identifiers (if any) are reported here. The presence of multiple patient identifiers will result in multiple REF segments.	
Example		REF*EA*002606567~	
Element ID	Usage	Valid Values	Comments
REF01	R	EA, SY, 1W	Reference Identification Number; EA = Medical Record Number SY = Social Security Number 1W = Member Identification Number (Beneficiary ID)
REF02	R		Reference Identification Number

Segment Name		**Rendering Provider Identification**	
Segment ID		REF	
Loop ID		2100	
Segment Usage		Situational	
Segment Notes		If both the NPI and the SD/MC Provider Number are submitted to identify the Service Facility Location, the NPI will be reported in Loop 2100 Segment NM1 and the SD/MC Provider Number will be reported here.	
Example		REF*1D*5924~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Number; 1D = Medicaid Provider Number
REF02	R		Reference Identification; SD/MC Provider Number

Segment Name		**Claim Date**	
Segment ID		DTM	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment provides claim date information.	
Example		DTM*050*20030814~	
Element ID	Usage	Valid Values	Comments
DTM01	R	050	Reference Identification Number Valid Values: 050 – Received Date
DTM02	R		Date Received by DMH (CCYYMMDD)

Segment Name		**Claim Supplemental Information**	
Segment ID		AMT	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		Claim Supplemental Information	
Example		AMT*F5*10~	
Element ID	Usage	Valid Values	Comments
AMT01	R	F5	Amount Qualifier Code; F5 = Patient Amount Paid
AMT02	R		Monetary Amount; The Medi-Cal Patient Share of Cost reported on the 837 in Loop 2300 Element AMT02 appears here.

Segment Name		**Service Payment Information**	
Segment ID		SVC	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		The number of SVC Segments can be >1 based on the number of services performed.	
Example		SVC*HC:H2012:HE:TG*85.5*0**0**4~	
Element ID	Usage	Valid Values	Comments
SVC01	R		Composite Medical Procedure Identifier
SVC01-01	R	HC	Product/Service ID Qualifier
SVC01-02	R		Procedure Code. This is the procedure or revenue code on the 837P and 837I.
SVC01-03	S		This is the first modifier reported on the procedure code from the 837P Transaction.
SVC01-04	S		This is the second modifier reported on the procedure code from the 837P Transaction.
SVC01-05	S		This is the third modifier reported on the procedure code from the 837P Transaction.
SVC01-06	S		This is the fourth Modifier Reported on the procedure code from the 837P Transaction
SVC01-07	N/A		Procedure Code Description; not used
SVC02	R		Line Item Charge Amount; amount billed.
SVC03	S		Line Item Provider Payment Amount/Approved Amount
SVC04	S		NUBC Revenue Code
SVC05	R		Quantity; Units of Service Paid Count. This value will be either units of service or units of time.
SVC06	N/A		Product / Service ID; not used
SVC07	S		Original Units of Service Quantity; Units of Service or Time Paid Count. This value is required when the value of SVC07 is different than SVC05.

Segment Name		**Service Date**	
Segment ID		DTM	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		This segment will be sent once for single day services and twice for multi-day services.	
Example		DTM*472*20030609~	
Element ID	Usage	Valid Values	Comments
DTM01	R		Date / Time Qualifier; Valid Values: 150 – Service Period Start 151 – Service Period End 472 – Service
DTM02	R		Date; The date is expressed in CCYYMMDD Format.

Segment Name		**Service Adjustment**	
Segment ID		CAS	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		Adjustments reflected here correlate to error messages and transaction codes.	
Example		CAS*CO*42*85.5*~	
Element ID	Usage	Valid Values	Comments
CAS01	R	CO, OA, PI, PR	Claim Adjustment Group Code; CO = Contractual Obligations OA = Other Adjustments PI = Payer Initiated Reductions PR = Patient Responsibility
CAS02	R		Adjustment Reason Code; See Table I: Transaction Code Denial Reason Error Code Crosswalk and Table J: Error Code Crosswalk
CAS03	R		Monetary Amount; This field contains the amount of the adjustment.

Segment Name		**Service Identification**	
Segment ID		REF	
Loop ID		2110	
Segment Usage		Required for 837P Claims Only	
Segment Notes		Service Identification	
Example		REF*6R*31063~	
Element ID	Usage	Valid Values	Comments
REF01	R	6R	6R = Line Item Control Number.
REF02	R		Matches number on 837P

Segment Name		**Rendering Provider Information**	
Segment ID		REF	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		This segment will appear once for each rendering provider that was reported at the service line level (2420A) on the 837.	
Example		REF*1D*5905~	
Element ID	Usage	Valid Values	Comments
REF01	R	HPI	HPI = NPI
REF02	R		NPI

Segment Name		**Service Supplemental Amount**	
Segment ID		AMT	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		This segment is used to convey information only. This is not part of the financial balancing of an 835 transaction. This segment may appear once for each Amount Qualifier Code.	
Example		AMT*B6*20~	
Element ID	Usage	Valid Values	Comments
AMT01	R	B6 or ZK	Amount Qualifier Code B6 = Allowed Amount or Actual Amount ZK = Federal Medicaid Payment Mandate (Category 1)
AMT02	R		Monetary Amount ; SD/MC Maximum Allowable Amount (for B6) Or SD/MC FFP Approved Amount (for ZK) appears only for approved claims.

Segment Name		**Health Care Remarks Code**	
Segment ID		LQ	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		Remarks reflected here combined with the adjustment reason codes in the CAS segment correlate to error messages and transaction code errors coming from SD/MC.	
Example		LQ*HE*MA130~	
Element ID	Usage	Valid Values	Comments
LQ01	R	HE	Code List Requirement Code
LQ02	R		Industry Code, see http://www.wpc-edi.com/codes/remittanceadvice and Table I: Transaction Code Denial Reason Error Code Crosswalk and Table J: Error Code Crosswalk

Segment Name		**Provider Adjustment**	
Segment ID		PLB	
Loop ID		Summary	
Segment Usage		Situational	
Segment Notes		One occurrence of this segment will be generated for each SD/MC Provider Number in the 835.	
Example		PLB*5914*20031231*CS:482003030101*0~	
Element ID	Usage	Valid Values	Comments
PLB01	R		Reference Identification; SDMC Provider Number
PLB02	R		Date; fiscal period date. If the fiscal date is not known, use December 31st of the current year.
PLB03-01	R	CS	Adjustment Reason Code
PLB03-02	R		Reference Identification; This is the SD/MC Batch Number.
PLB04	R		Monetary Amount; This amount reflects the sum of all approved amounts for services for the SD/MC Provider Number.

Segment Name		**Transaction Set Trailer**	
Segment ID		SE	
Loop ID		Summary	
Segment Usage		Required	
Segment Notes		Transaction Set Trailer Counts	
Example		SE*26*0196~	
Element ID	Usage	Valid Values	Comments
SE01	R		Number of included segments
SE02	R		Transaction Set Control Number. Must match the value sent in the ST02 field.

5.7 EXAMPLE OF AN 835 RECORD

	Interchange Control Header
1	ISA*00* *00* *ZZ*INFOTECHWEBSVCS*ZZ*C59000000000000*030930*1256*U*00401*00000636*0*P*:~
	Functional Group Header
2	GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A1~
	Transaction Set Header (835)
3	ST*835*0001~
4	BPR*H*0*C*NON**********20031001~
5	TRN*1*592003061003*1482003030*DMH~
6	REF*EV*59~
7	DTM*405*20030820~
	Payer Identification (1000A)
8	N1*PR*01~
9	N3*1600 Ninth Street~
10	N4*SACRAMENTO*CA*95814~
	Payee Identification (1000B)
11	N1*PE*York County Health Care Agency*FI*956000928~
	Header Number (2000)
12	LX*1~
	Claim Payment Information (2100)
13	CLP*1887*25*300.5*0**MC~
14	NM1*QC*1*Jones*John*J***HN*1234567890~
15	NM1*74*1******C*596091002839A~
16	NM1*82*2******MC*5905~
17	NM1*PR*2*Medicare Part A and Part B*****PI*Z~
18	REF*EA*002606567~
19	REF*SY*548909368~
20	REF*1W*596HM548909368~
21	DTM*050*20030814~
22	AMT*F5*10~

	Service Payment Information (2110)				
23	SVC*HC:H2012:HE*100.5*73.77**4~				
24	DTM*472*20030609~				
25	CAS*CO*42*26.73~				
26	REF*6R*31063~				
27	REF*1D*5905~				
28	AMT*B6*73.77~				
29	LQ*HE*N59~				
30	SVC*HC:H2012:HE:*90*73.77**4~				
31	DTM*472*20030610~				
32	CAS*CO*42*16.23~				
33	REF*6R*31064~				
34	REF*1D*5905~				
35	AMT*B6*73.77~				
36	LQ*HE*N59~				
37	SVC*HC:H2012:HE*110*73.77**4~				
38	DTM*472*20030611~				
39	CAS*CO*42*36.23				
40	REF*6R*31065~				
41	REF*1D*5905~				
42	AMT*B6*73.77~				
43	LQ*HE*N59~				
	Claim Payment Information (2100)				
44	CLP*1234567891*25*1050.6*0**MC~				
45	NM1*QC*1*LastName*FirstName2*MI***HN*1234567891~				
46	NM1*74*1******C*5920998765432C~				
47	NM1*82*2******MC*5905~				
48	REF*EA*0872~				
49	REF*SY*551732045~				
50	REF*1W*5920M987654231~				
51	DTM*050*20030814~				
52	AMT*F5*0~				

	Service Payment Information (2110)
53	SVC*HC:H2011:HE*1050.6*920.7**18~
54	DTM*472*20030604~
55	CAS*CO*42*129.9~
56	REF*6R*31066~
57	REF*1D*5905~
58	AMT*B6*3.41~
59	LQ*HE*N59~
	Claim Payment Information (2100)
60	CLP*31067*25*3900*2514.6*0**MC~
61	NM1*QC*1*LastName*FirstName2*MI***HN*1234567891~
62	NM1*74*1******C*5920998765432C~
63	NM1*82*2******MC*5905~
64	REF*EA*0872~
65	REF*SY*551732045~
66	REF*1W*5920M987654231~
67	DTM*050*20030814~
68	AMT*F5*0~
	Service Payment Information (2110)
69	SVC*HC:H2015:HE*3900*2514.6*0100*3~
70	DTM*150*20030604~
71	DTM*151*20030607~
72	CAS*CO*42*1385.4~
73	REF*1D*5905~
74	AMT*B6*838.2~
75	LQ*HE*N59~
	Summary (835)
76	PLB*5905*20031231*CS:592003065001*3656.61~
77	SE*55*0002~
	Functional Group Trailer
78	GE*5*614~
	Interchange Control Trailer
79	IEA*1*000000636~

6 CROSSWALK MAPPINGS AND OTHER TABLES

6.1 TABLE A – 837P MODE OF SERVICE/SERVICE FUNCTION CROSSWALK

COST REPORTS & CSI		SD/MC CLAIM SERVICE CODES		HIPAA 837 P SERVICE CODES					
Mode of Service	**Mode of Service**	**Service Function**	**Service Description**	**Procedure Code**	**Unit or Basis for Measurement Code**	**Procedure Modifier 1**	**Procedure Modifier 2**	**Place Of Service Code**	**Taxonomy Code**
05	05	20-29	Psychiatric Health Facility (PHF)	H2013	Unit = day	HE			
05	05	40-49	Adult Crisis Residential	H0018	Unit = day	HE	HB, HC		
05	05	65-79	Adult Residential	H0019	Unit = day	HE	HB, HC		
10	12	20-24	Crisis Stabilization	S9484	Unit = hour	HE	TG	23	282N00000X 283Q00000X
10	12	25-29	Crisis Stabilization	S9484	Unit = hour	HE	TG	20	282N00000X 283Q00000X
10	12	81-84	Day TX Intensive Half Day	H2012	Unit = 1 hour (use 4 units)	HE	TG		282N00000X 283Q00000X
10	12	85-89	Day TX Intensive Full Day	H2012	Unit = 1 hour (use 6 units)	HE	TG		282N00000X 283Q00000X
10	12	91-94	Day TX Habilitative Half Day	H2012	Unit = 1 hour (use 4 units)	HE			282N00000X 283Q00000X
10	12	95-99	Day TX Habilitative Full Day	H2012	Unit = 1 hour (use 6 units)	HE			282N00000X 283Q00000X
15	12	01-08	Linkage/Brokerage	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	09	Linkage/Brokerage Professional IP Visit	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
15	12	10-18 30-38 40-48 50-57	MHS	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X

COST REPORTS & CSI	SD/MC CLAIM SERVICE CODES			HIPAA 837 P SERVICE CODES					
Mode of Service	**Mode of Service**	**Service Function**	**Service Description**	**Procedure Code**	**Unit or Basis for Measurement Code**	**Procedure Modifier 1**	**Procedure Modifier 2**	**Place Of Service Code**	**Taxonomy Code**
15	12	19, 39, 49, 59	MHS - Professional IP Visit	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
15	12	58	TBS	H2019	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	60-68	Medication Support	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	69	Medication Support-Professional IP Visit	H2010	Unit = 15 minutes (Bill in one-minute increments)[1]	HE		21, 51	282N00000X 283Q00000X
15	12	70-78	Crisis Intervention	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X,283Q00000X
15	12	79	Crisis Intervention-Professional IP Visit	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
10	18	20-24	Crisis Stabilization	S9484	Unit = hour	HE	TG	23	
10	18	25-29	Crisis Stabilization	S9484	Unit = hour	HE	TG	20	
10	18	81-84	Day TX Intensive Half Day	H2012	Unit = 1 hour (use 4 units)	HE	TG		
10	18	85-89	Day TX Intensive Full Day	H2012	Unit = 1 hour (use 6 units)	HE	TG		
10	18	91-94	Day TX Habilitative Half Day	H2012	Unit = 1 hour (use 4 units)	HE			
10	18	95-99	Day TX Habilitative Full Day	H2012	Unit = 1 hour (use 6 units)	HE			

COST REPORTS & CSI	SD/MC CLAIM SERVICE CODES		HIPAA 837 P SERVICE CODES						
Mode of Service	**Mode of Service**	**Service Function**	**Service Description**	**Procedure Code**	**Unit or Basis for Measurement Code**	**Procedure Modifier 1**	**Procedure Modifier 2**	**Place Of Service Code**	**Taxonomy Code**
15	18	01-08	Linkage/Brokerage	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	09	Linkage/Brokerage Professional IP Visit	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	10-18 30-38 40-48 50-57	MHS	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	19, 39, 49, 59	MHS - Professional IP Visit	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	58	TBS	H2019	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	60-68	Medication Support	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	69	Medication Support-Professional IP Visit	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	70-78	Crisis Intervention	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	79	Crisis Intervention-Professional IP Visit	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	

[1] Refer to table B, Minutes to Units Conversion, for instructions on completing the Units field.

PROCEDURE CODE DEFINITIONS (HCPCS)	
H0018	Behavioral Health: Short-Term Residential. Non-hospital - Without Room & Board per diem.
H0019	Behavioral Health: Long term Residential Non-Acute, non-medical, usually longer than 30 days.
H2010	Comprehensive Medication Services - per 15 minutes
H2011	Crisis Intervention - per 15 minutes
H2012	Behavioral Health Day Treatment - per 1 hour
H2013	Psychiatric Health Facility - per diem
H2015	Comprehensive Community Support - per 15 minutes
H2019	Therapeutic Behavioral Service - per 15 minutes
S9484	Crisis Intervention Mental Health Service - Per Hour
T1017	Targeted Case Management - per 15 minutes

MODIFIER CODE DEFINITIONS	
HB	Adult Program, Non-Geriatric
HC	Adult Program Geriatric
HE	Mental Health Program
TG	Complex/High Technical Level of Care

PLACE OF SERVICE CODE DEFINITIONS	
20	Urgent Care
21	Hospital Inpatient
23	Hospital ER
51	Inpatient Psychiatric Facility

TAXONOMY CODE DEFINITIONS	
282N00000X	General Hospital
283Q00000X	Psychiatric Hospital

MODE OF SERVICE DEFINITIONS (SHORT-DOYLE / MEDI-CAL MODE DEFINITIONS)	
05	24-Hour non-Hospital Services
12	Outpatient Hospital Services
18	Non-Residential Rehabilitative Treatment

COST REPORTS & CSI MODE OF SERVICE DEFINITIONS	
05	24-Hour Services
10	Day Services
15	Outpatient Services

NOTE: Claredi requires Procedure Modifiers to be filled in starting with Modifier 1, then 2, 3, and 4. That is, if Procedure Modifier fields1 and 4 are filled with valid values and Procedure Modifier fields 2 and 3 are blank, Claredi will reject the record.

6.2 TABLE B – MINUTES TO UNITS CONVERSION

To convert minutes to units of 15-minute increments, multiply each minute of service by 1/15 (0.066667)* and round to two decimal places. The translator will multiply the resulting units by 15 and round to zero decimal places to obtain the minutes.

COUNTY FUNCTION			STATE FUNCTION	
Col 1	Col 2	Col1*Col2 Rounded	Col 4	Col3*Col4 Rounded
Minutes to Units			Units to Minutes	
Minutes	Multiplication Factor	Units	Multiplication Factor	Minutes
1	0.066667	0.07	15	1
2	0.066667	0.13	15	2
3	0.066667	0.20	15	3
4	0.066667	0.27	15	4
5	0.066667	0.33	15	5
6	0.066667	0.40	15	6
7	0.066667	0.47	15	7
8	0.066667	0.53	15	8
9	0.066667	0.60	15	9
10	0.066667	0.67	15	10
11	0.066667	0.73	15	11
12	0.066667	0.80	15	12
13	0.066667	0.87	15	13
14	0.066667	0.93	15	14
15	0.066667	1.00	15	15
16	0.066667	1.07	15	16
17	0.066667	1.13	15	17
18	0.066667	1.20	15	18
19	0.066667	1.27	15	19
20	0.066667	1.33	15	20
25	0.066667	1.67	15	25
30	0.066667	2.00	15	30
40	0.066667	2.67	15	40
45	0.066667	3.00	15	45
50	0.066667	3.33	15	50
60	0.066667	4.00	15	60
90	0.066667	6.00	15	90
120	0.066667	8.00	15	120
180	0.066667	12.00	15	180

* When converting minutes to units, do not round the multiplication factor (0.66667); round only the end result.

COUNTY FUNCTION			STATE FUNCTION	
Col 1	**Col 2**	**Col1*Col2 Rounded**	**Col 4**	**Col3*Col4 Rounded**
Minutes to Units			**Units to Minutes**	
Minutes	**Multiplication Factor**	**Units**	**Multiplication Factor**	**Minutes**
240	0.066667	16.00	15	240

6.3 TABLE C – 837I (INSTITUTIONAL) SERVICE CODE CROSSWALK

COST REPORTS & CSI	SD/MC CLAIM SERVICE CODES			HIPAA 837 I SERVICE CODES				
Mode of Service	**Mode of Service**	**Service Function**	**Service Description**	**Revenue Code**	**Unit or Basis for Measurement Code**	**Procedure Code**	**Procedure Modifier 1**	**Procedure Modifier 2**
05	07	10-18	Hospital Inpatient	0100	DA (day)	H2015	HE	
05	07	19	Hospital Inpatient - Administrative Day	0101	DA (day)	H0046	HE	
05	08	10-18	Hospital Inpatient - Psychiatric Hospital under age 21	0100	DA (day)	H2015	HE	HA
05	08	19	Hospital Inpatient - Administrative Day - Psychiatric Hospital under age 21	0101	DA (day)	H0046	HE	HA
05	09	10-18	Hospital Inpatient - Psychiatric Hospital over age 64	0100	DA (day)	H2015	HE	HC
05	09	19	Hospital Inpatient - Administrative Day - Psychiatric Hospital over age 64	0101	DA (day)	H0046	HE	HC

HIPAA Service Code Definitions	
Procedure Code Definitions (HCPCS)	
H2015	Mental Health Service
H0046	Mental Health Service Not Elsewhere Classified

Modifier Code Definitions	
HA	Child/Adolescent Program
HB	Adult Program, Non-Geriatric
HC	Adult Program Geriatric
HE	Mental Health Program

Revenue Code Definitions	
0100	Room and Board, Plus ancillaries
0101	Room and Board only

Short-Doyle/Medi-Cal Mode Definitions	
07	Inpatient Hospital Services
08	Psychiatric Hospital (Inpatient) - Under 21
09	Psychiatric Hospital (Inpatient) - 65 or Over

Cost Reports & CSI Mode of Service Definitions	
05	24-Hour Services

NOTE: Claredi requires Procedure Modifiers to be filled in starting with Modifier 1, then 2, 3, and 4. That is, if Procedure Modifier fields1 and 4 are filled with valid values and Procedure Modifier fields 2 and 3 are blank, Claredi will reject the record.

6.4 TABLE D – CROSSOVER INDICATOR CROSSWALK

ORDER OF DETERMINATION	CLAIM LEVEL FIELD NAME 1	VALUE 1	CLAIM LEVEL FIELD NAME 2	VALUE 2	QUALIFIERS	SERVICE LEVEL FIELD	SD/MC CODE	SD/MC CODE DESCRIPTION
1	CLM07-Medicare Assignment Code	A, B, or P	Loop 2320 is not present				Blank	No Medicare or other health coverage
2	CLM07-Medicare Assignment Code	C	Loop 2320 is not present				H	Non-Medicare certified provider
3	Loop 2320, SBR09-Claim Filing Indicator Code	10, 11, 12, 13, 14, 15, AM, BL, CH, CI, DS, HM, LI, LM, OF, TV, VA, WC, ZZ					P	Other health coverage
4	Loop 2320, SBR09-Claim Filing Indicator Code	MB or 16 for 837P MA, MB, or 16 for 837I	Loop 2320, AMT02 Payer Paid Amount and AMT02 Allowed Amount for 837P Loop 2320, AMT02 Prior Payer Payment and AMT02 Allowed Amount for 837I	0 (Zero)	837P: D for Payer Paid Amount B6 for Allowed Amount 837I: C4 for Prior Payer Payment B6 for Allowed Amount	Loop 2430, SVD02 Service Line Paid Amount not present or is equal to zero	N	Medicare covered recipient; however, Medicare either denied the claim or the claim is for services that Medicare does not cover.

ORDER OF DETERMINATION	CLAIM LEVEL FIELD NAME 1	VALUE 1	CLAIM LEVEL FIELD NAME 2	VALUE 2	QUALIFIERS	SERVICE LEVEL FIELD	SD/MC CODE	SD/MC CODE DESCRIPTION
5	Loop 2320, SBR09-Claim Filing Indicator Code	MB or 16 for 837P MA, MB, or 16 for 837I	837P: Loop 2320, AMT02 Payer Paid Amount and AMT02 Allowed Amount 837I: Loop 2320, AMT02 Prior Payer Payment and AMT02 Allowed Amount	Greater than zero.	837P: D for Payer Paid Amount B6 for Allowed Amount 837I: C4 for Prior Payer Payment B6 for Allowed Amount	Loop 2430, SVD02 Service Line Paid Amount is greater than zero	X	Medicare coverage
6						SVD02 = 0		

6.5 TABLE E - DUPLICATE PAYMENT OVERRIDE CODE CROSSWALK

SD/MC CODE	SD/MC CODE DESCRIPTION	PROCEDURE MODIFIER	MODIFIER DESCRIPTION
Y	Override duplicate billing edit	59	Distinct Procedural Service
Y	Override duplicate billing edit	76	Repeat Procedure by Same person
Y	Override duplicate billing edit	77	Repeat Procedure by Different person
Blank	Do not override duplicate billing edit		

If a procedure modifier of 59, 76, or 77 appears at the service line the "Translator" will put a "Y" in the "Duplicate Payment Override" field on the SD/MC claim legacy system.

6.6 TABLE F - DELAY REASON CODE CROSSWALK

SD/MC LATE BILLING OVERRIDE CODE	DESCRIPTION	HIPAA DELAY REASON CODE	HIPAA DESCRIPTIONS
A	Patient or legal representative's failure to present Medi-Cal identification	1	Proof of Eligibility Unknown or Unavailable
B	Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAMPUS	7	Third Party Processing Delay
C	Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or County.	8	Delay in Eligibility Determination
D	Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable.	4, 11	4=Delay in Certifying Provider 11=Other
E	Special circumstances that cause a billing delay such as a court decision or fair hearing decision.	10	Administrative Delay in Prior Approval Process.
F	Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC).	2	Litigation
Blank	Do not override late billing		

6.7 TABLE G - MAPPING THE SD/MC EOB CODES TO THE 835

SORT KEY (CLAIM ADJUDICATION TYPE)		CLAIM STATUS CODE	
A	Approved Claim	25	Predetermination Pricing Only, No payment
D	Denied Claim	4	Denied
G	Aged Suspended Claim	4	Denied
S	Suspended Claim	13	Suspended

If at least one service on a claim is approved, code "25" will be used. Review the service level information to determine if any lines have been suspended or denied.

If all services have been denied, either due to edits (D) or aging (G), code "4" will be used.

If all services have been suspended, code "13" will be used.

6.8 TABLE H - THIRD PARTY LIABILITY INDICATOR CROSSWALK

SDMC EOB VALUE	835 VALUE	VALUE DESCRIPTION
A	AC	Any Carrier - Pay and Chase
C	CH	CHAMPUST Prime HMO
F	FM	Medicare HMO
K	KA	Kaiser
L	LD	Dental Only Policies
P	PH	PHP/HMOs or EPO (Exclusive Provider Option)
V	VA	Variable - any carrier other than the above, includes multiple coverage
9	9H	Healthy Families Program
*	XM	Medicare Part A only
#	YM	Medicare Part B only
$	ZM	Medicare Part A and Part B
N	n/a*	None
O	n/a*	Override
Blank	n/a*	No Medicare and No TPL/OHC
M	MU	Two or more carriers
X	BS	Blue Shield

SDMC EOB VALUE	835 VALUE	VALUE DESCRIPTION
Z	BC	Blue Cross
B	BD	Blue Cross
D	PR	Prudential
E	AE	Aetna
G	GA	General American
H	MO	Mutual of Omaha
I	ML	Metropolitan Life
J	JH	John Hancock
S	BT	Blue Shield
T	TR	Travelers
U	CG	Connecticut General/Equator/Cigna
W	GW	Great West Life
2	PL	Provident Life and Accident
3	PF	Principal Financial Group
4	PM	Pacific Mutual Life
5	AH	Alta Health Strategies
6	AA	AARP
8	NY	New York Life

* - These values will not cause data to be populated on the 835.

6.9 TABLE I – TRANSACTION CODE DENIAL REASON ERROR CODE CROSSWALK

A. ORIGINAL CLAIMS					
SD/MC CODES AND MESSAGES		HIPAA **ADJUSTMENT REASON AND REMARKS CODES**			
SD/MC Error Code	**SD/MC Error Message**	**Adj. Group CAS01**	**Adj. Reason CAS02**	**Remarks Code LQ02**	**Comments**
C	Unprocessable, invalid claim ID	CO	16	MA130	
D	Unprocessable, duplicate claim ID	CO	18	MA130	
F	Failed Edits (Approve/Deny) County Option	CO	A1	MA130	
N	Deny claim with non-Title XIX determination	CO	31	MA130	
O	Unprocessable, invalid override code	CO	138	MA130	
R	Unprocessable, Receipt date error		n/a		Will be generated by state.
S	Unprocessable, duplicate claim ID on Suspense	CO	18	MA130	
T	Deny claim with tape submission error		n/a		Not applicable to HIPAA transactions.
X	County requested denial of claim on suspense	OA	A1	MA130	
Blank	Claim denied after 97 days on suspense	CO	B5	MA130	
B. VOID TRANSACTIONS					
SD/MC CODES AND MESSAGES		**HIPAA ADJUSTMENT REASON AND REMARKS CODES**			
SD/MC Error Code	**SD/MC Error Message**	**Adj. Group CAS01**	**Adj. Reason CAS02**	**Remarks Code LQ02**	**Comments**
A	Void error – Duplicate (original claim already voided)	CO	18		
B	Void error – Received date of void is prior to VCR inception	CO	138		
E	Void error – Edit failed	CO	16	MA130	This code appears when error type does not match any other code.
I	Void error – No match on secondary fields (Beneficiary ID/Service Date)	CO	A1		
L	Void error – Original claim older than 18 months from month of service)	CO	29		
P	Void error – Invalid date format	CO	16		
U	Void error – No match on primary fields (unique ID/County Code).	CO	A1		
M	Void Transaction – Match found, void successful	n/a	n/a	n/a	Not applicable to HIPAA transactions.

6.10 TABLE J - SD/MC ERROR CODE CROSSWALK

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
01	Data element is BLANK	203-204 Gender	CO	31	MA39	
01	Data element is BLANK	205-206 DOB year	CO	31		
01	Data element is BLANK	207-208 Service YYYYMM	CO	B18	MA66	
01	Data element is BLANK	211-212 Mode of Service	CO	B7	M51	
01	Data element is BLANK	215-216 Service Function	CO	B7	M51	
01	Data element is BLANK	221-222 Total Billed Amount	CO	16	M54	
01	Data element is BLANK	223-224 Claim For Date Claim Submitted	CO	16		
01	Data element is BLANK	229-230 Race/Ethnicity				N/A. Value will be populated from MEDS.
02	Not a valid date	205-206 DOB year	CO	31		
02	Not a valid date	207-208 Service YYYYMM	CO	16	MA66	
02	Not a valid date	231-232 Service/Treatment Date	CO	16	MA66	
03	Invalid code	199-200 Crossover Indicator	CO	16		
03	Invalid code	201-202 Welfare ID	CO	31	MA61	
03	Invalid code	203-204 Gender	CO	31	MA39	
03	Invalid code	209-210 Provider Code	CO	B7		
03	Invalid code	211-212 Mode of Service	CO	B7	M51	
03	Invalid code	215-216 Service	CO	B7	M51	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
		Function				
03	Invalid code	229-230 Race/Ethnicity				N/A
03	Invalid code	233-234 Discharge Indicator	CO	16	N50	
03	Invalid code	235-236 Diagnosis	CO	16	M81	
04	Late submission	207-208 Service YYYYMM	CO	29		
05	Not valid day	231-232 Service/Treatment Date	CO	16	MA66	
06	Not numeric	205-206 DOB year	CO	31	MA66	
06	Not numeric	207-208 Service YYYYMM	CO	16	MA66	
06	Not numeric	209-210 Provider Code	CO	B7		
06	Not numeric	211-212 Mode of Service	CO	B7	M51	
06	Not numeric	217-218 Units of Time	CO	16	N59	
06	Not numeric	219-220 Units of Service	CO	16	N59	
06	Not numeric	221-222 Billed Amount	CO	16	M54	
06	Not numeric	227-228 Admit Date	CO	16	MA40	
06	Not numeric	231-232 Service/Treatment Date	CO	16	MA66	
07	Zero Claimed	217-218 Units of Time	CO	16	M53	
07	Zero Claimed	221-222 Billed Amount	CO	16	M54	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
08	Mode not authorized	211-212 Mode of Service	CO	B7	N65	
08	Mode not authorized	209-210 Provider Code	CO	B7		
09	Ineligible in month and year	201-202 Welfare ID	PR	26	N59	
09	Ineligible in month and year	207-208 Service YYYYMM	PR	26	N59	
09	Ineligible in month and year	209-210 Provider Code	CO	B7		
10	Conflicts with eligibility file	199-200 Crossover Indicator	CO	16		
10	Conflicts with eligibility file	203-204 Gender	CO	31	MA21	
10	Conflicts with eligibility file	205-206 DOB year	CO	31		
10	Conflicts with eligibility file	225-226 Name	CO	31	MA21	
11	Not on eligibility file.	201-202 Welfare ID	PR	31	N59	
12	Not on DHS provider file	209-210 Provider Code	PI	B7		
13	Program not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56	
13	Program not authorized in month and year	209-210 Provider Code	CO	B7		
13	Program not authorized in month and year	211-212 Mode of Service	CO	B7	N56	
14	Mode not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56	
14	Mode not authorized in month and year	209-210 Provider Code	CO	B7		
14	Mode not authorized in month and year	211-212 Mode of Service	CO	B7	N56	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
15	No secondary match	201-202 Welfare ID	CO	31	N59	
16	Service date greater than receipt date.	207-208 Service YYYYMM	CO	110	N59	
17	Healthy Families hold period.	201-202 Welfare ID	CO	16	M16	
17	Healthy Families hold period.	207-208 Service YYYYMM	CO	16	M16	Counties receiving this combination should review DMH Information Letter 98-14 for additional information.
18	Claim too old for eligibility check	201-202 Welfare ID	CO	31	N1	
19	Invalid Service Function Code	215-216 Service Function	CO	B7	N65	
20	Units of service are not less than or equal to the units of time	217-218 Units of Time	CO	16	M53	
20	Units of service are not less than or equal to the units of time	219-220 Units of Service	CO	16	M53	
21	Invalid drug code	235-236 Diagnosis	CO	11	MA63	
22	Date range not allowed	231-232 Service/Treatment Date	CO	16	N74	
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	197-198 Duplicate	CO	119	M86	
23	Units of service are greater than allowed (in	217-218 Units of Time	CO	119	M53	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
	Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).					
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	219-220 Units of Service	CO	119	M53	
24	To date is greater than from date.	231-232 Service/Treatment Date	CO	16	MA31	
25	Units not equal to days.	217-218 Units of Time	CO	16	M53	
25	Units not equal to days.	219-220 Units of Service	CO	16	M53	
25	Units not equal to days.	221-222 Billed Amount	CO	42	M54	
25	Units not equal to days.	233-234 Discharge Indicator	CO	16	M53	
26	Duplicate Service - No Override	197-198 Duplicate	CO	18	M86	
27	Multiple Service - Override OK	197-198 Duplicate	CO	18	M80	
28	Greater than two outpatient services	197-198 Duplicate	CO	119	N59	
29	Service Function Not Authorized	215-216 Service Function	CO	B7	N65	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
30	Service Function Not Authorized in month and year	215-216 Service Function	CO	B7	N65	
31	Medicare Coverage Part ____, HIC # _____	199-200 Crossover Indicator	CO	16		
31	Medicare Coverage Part ____, HIC # _____	221-222 Billed Amount	CO	16		
32	Other Coverage Indicator ____	199-200 Crossover Indicator	CO	16	MA92	
32	Other Coverage Indicator ____	221-222 Billed Amount	CO	16	MA92	
33	Claims less than two days of LAAM dose	197-198 Duplicate	CO	B5	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	197-198 Duplicate	CO	18	N20	
34	Dollars greater than allowed	217-218 Units of Time	CO	42	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	219-220 Units of Service	CO	42	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	221-222 Billed Amount	CO	42	N14 Inactive as of 10-1-07	
35	Two doses in one day not allowed	197-198 Duplicate	CO	119	M86	

6.11 TABLE K – CROSSWALK 837P TO SD/MC MODE OF SERVICE AND SERVICE FUNCTIONS

Table K describes how 837 revenue/procedure codes, modifiers, place of service, provider taxonomy, and units will be used to create the current Short-Doyle/Medi-Cal Mode of Service and Service Function Codes that will be used for claim processing and how they appear on the EOB.

HIPAA PROCEDURE, MODIFIER, PLACE OF SERVICE, AND TAXONOMY CODES						SD/MC CLAIM	
SV101-2	SV101-3	SV101-4	SV104	SV105	PRV03		
(Procedure Code)	(Modifier-1)	(Modifier-2)	(Units)	(Place of Service)	(Provider Taxonomy)	Mode of Service	Service Function
H2013	HE					5	20
H0018	HE	HB or HC				5	40
H0019	HE	HB or HC				5	65
S9484	HE	TG		23	282N00000X or 283Q00000X	12	20
S9484	HE	TG		20	282N00000X or 283Q00000X	12	25
H2012	HE	TG	4		282N00000X or 283Q00000X	12	81
H2012	HE	TG	6		282N00000X or 283Q00000X	12	85
H2012	HE		4		282N00000X or 283Q00000X	12	91
H2012	HE		6		282N00000X or 283Q00000X	12	95
T1017	HE				282N00000X or 283Q00000X	12	1
T1017	HE			21 or 51	282N00000X or 283Q00000X	12	9
H2015	HE				282N00000X or 283Q00000X	12	30
H2015	HE			21 or 51	282N00000X or 283Q00000X	12	39
H2019	HE				282N00000X or 283Q00000X	12	58
H2010	HE				282N00000X or 283Q00000X	12	60
H2010	HE			21 or 51	282N00000X or 283Q00000X	12	69
H2011	HE				282N00000X or 283Q00000X	12	70
H2011	HE			21 or 51	282N00000X or 283Q00000X	12	79
S9484	HE	TG		23		18	20

HIPAA PROCEDURE, MODIFIER, PLACE OF SERVICE, AND TAXONOMY CODES						SD/MC CLAIM	
SV101-2	SV101-3	SV101-4	SV104	SV105	PRV03		
(Procedure Code)	(Modifier-1)	(Modifier-2)	(Units)	(Place of Service)	(Provider Taxonomy)	Mode of Service	Service Function
S9484	HE	TG		20		18	25
H2012	HE	TG	4			18	81
H2012	HE	TG	6			18	85
H2012	HE		4			18	91
H2012	HE		6			18	95
T1017	HE					18	1
T1017	HE			21 or 51		18	9
H2015	HE					18	30
H2015	HE			21 or 51		18	39
H2019	HE					18	58
H2010	HE					18	60
H2010	HE			21 or 51		18	69
H2011	HE					18	70
H2011	HE			21 or 51		18	79

6.12 TABLE L – CROSSWALK 837I TO SD/MC MODE AND SERVICE FUNCTIONS

Table L describes how 837 revenue/procedure codes, modifiers, place of service, provider taxonomy, and units will be used to create the current Short-Doyle/Medi-Cal Mode of Service and Service Function Codes that will be used for claim processing and how they appear on the EOB.

HIPAA REVENUE, PROCEDURE, AND MODIFIER CODES				SD/MC CLAIM	
SV201 (Revenue Code)	**SV202-2 (Procedure Code)**	**SV202-3 (Modifier-1)**	**SV202-4 (Modifier-2)**	**Mode of Service**	**Service Function**
0100	H2015	HE		07	10
0101	H0046	HE		07	19
0100	H2015	HE	HA	08	10
0101	H0046	HE	HA	08	19
0100	H2015	HE	HC	09	10
0101	H0046	HE	HC	09	19

6.13 TABLE M – TRANSLATOR ERRORS (837) LIST

#	ERROR SOURCE	VALUE REQUIRED/ EXPECTED	EDIT RESULT	ERROR CATEGORY	ERROR RESOLUTION	ERROR MESSAGE
1	Claim ID - Claim Type	ADP/DMH	Correct value not found	FATAL	Reject the ST-SE segment	The value 'A' was not found for the Claim Type, instead found xxxxx … Transaction Aborted
2	Claim ID - Provider Code	4 digit code	No code found at any level	FATAL	Reject the ST-SE segment	The provider code was not found or was of invalid length … Transaction Aborted
3	Claim ID - Provider Code	4 digit code	Code found but has invalid length (e.g. > 4 digits)	FATAL	Reject the ST-SE segment	The provider code was not found or was of invalid length … Transaction Aborted
4	Claim ID - Provider Code	4 digit code	Codes in 2300 and 2400 loops don't match	INFO	use code from 2400 loop	Provider Code Mismatch : 2300 code - xxxx , 2400 code - xxxx
5	Claim ID - Claim Serial	5 digit code	No code found	FATAL	Reject the ST-SE segment	The claim serial number was not found ... Transaction Aborted
6	Program Code	"01" for DMH, 20 or 25 for ADP	No Value Found or Incorrect Value Found	FATAL	Reject the ST-SE segment	Invalid program code… Transaction Aborted
7	Program Code/Mode of Service	one result from database query	No code translation is found	FATAL	Reject the ST-SE segment	No code crosswalk found… Transaction Aborted
8	Program Code/Mode of Service	one result from database query	Multiple translations are found	FATAL	Reject the ST-SE segment	Multiple code crosswalks found. Transaction Aborted
9	Patient Name	last and first names (total 14 chars)	Last or First Name greater than the required number of characters	INFO	Use whole Last Name or first 11 Characters of Last Name and 3 characters of First Name	Patient Name truncated to fit the 14 character field.
10	Patient record number	<= 9 characters long	Longer than 9 characters	INFO	Use the first 9 characters	Patient Record number has been truncated to fit the 9 character field.
11	Beneficiary ID	<= 14 characters long	longer than 14 characters	FATAL	Reject the ST-SE segment	Beneficiary ID length is too long, transaction aborted.

#	Error Source	Value Required/ Expected	Edit Result	Error Category	Error Resolution	Error Message
12	Service first and last dates	Must be within the same month and year.		FATAL	Reject the ST-SE segment	Claim cannot cross months and years, transaction aborted
13	Units of Time	4 digit code needs to be populated in units of time field	a value grater than 9999	FATAL	Reject the ST-SE segment	Invalid Units of Time, transaction aborted.
14	Units of Service	3 digit code needs to be populated in units of service field	SV104 rounded value is greater than 999	FATAL	Reject the ST-SE segment	Invalid Units of Service, transaction aborted.
15	Total Billed Amount	a double value	Value greater than 8 characters long	FATAL	Reject the ST-SE segment	Invalid length of Total Amount Billed, transaction aborted.
16	Late Billing Override Code	specific 2-digit codes	No code translation found in database	FATAL	Reject the ST-SE segment	Invalid Late Billing Override Code, transaction aborted.
17	Late Billing Override Code	specific 2-digit codes	Multiple code translation found in database	FATAL	Reject the ST-SE segment	Invalid Late Billing Override Code, transaction aborted.
18	Crossover indicator	2 digit code	SBR09 is not from the list of valid codes	FATAL	Reject the ST-SE segment	No value or unknown value found, transaction aborted.
Error Codes Pertaining to VCR Transactions						
#	Error Source	Value Required/ Expected	Edit Result	Error Category	Error Resolution	Error Message
19	Frequency Type Code (both original and VCR 837s)	1-Digit Code: 1 = Original Claim 1+ORN = Correction 7 = Replacement 8 = Void	No value found or unknown value found.	FATAL	Reject the transaction.	Not a valid Frequency Type Code.

#	ERROR SOURCE	VALUE REQUIRED/ EXPECTED	EDIT RESULT	ERROR CATEGORY	ERROR RESOLUTION	ERROR MESSAGE
20	Original Reference Number (VCR 837 only)	Unique ID of original claim.	No value found or no match found.	FATAL	Reject the transaction.	No value or no match found (in PT table). Transaction aborted.
21	Claim Submitter Identifier (both original and VCR 837s)	Unique ID (for submitting County) must be present.	No value found or value not unique.	FATAL	Reject the transaction.	No value found or not unique for individual County.
22	Service Line Level (Loop 2400) (VCR 837 only)	Only one service line per claim allowed.	Multiple service lines found.	FATAL	Reject the transaction.	Multiple service lines found for one claim line.
23	VCR Inception Date (Submission Date) (VCR 837 only)	Only original claims submitted after VCR inception can use VCR functionality.	VCR transaction submitted for original claim received prior to VCR inception.	FATAL	Reject the transaction.	VCR transaction found for an original claim submitted before VCR inception.
24	Single Correction (VCR 837 only)	Claims can only be corrected once.	Original target claim has already been corrected once.	FATAL	Reject the transaction.	Claim (ID xxx) has been already corrected once.
25	Previous Void Must Be Received for Replacement (VCR 837 only)	Previous void received for replacement transaction.	Cannot find a previously submitted void for this replacement transaction.	FATAL	Reject the transaction.	No corresponding void found for the replacement claim: Replacement claim ID:xxx Original claim ID:xxx
26	Only One Replacement for Original Claim (VCR 837 only)	Claims can only be replaced once.	Multiple replacements found for same original claim.	FATAL	Reject the transaction.	Claim (ID xxx) has been already been replaced once.

#	ERROR SOURCE	VALUE REQUIRED/ EXPECTED	EDIT RESULT	ERROR CATEGORY	ERROR RESOLUTION	ERROR MESSAGE
27	Only One Void Claim Per Original Claim In A Single File (VCR 837 only)	Only one void can be submitted for a single original claim in the same file.	Multiple void transactions found targeting same original claim in a single file.	FATAL	Reject the transaction.	Multiple void claims for one original claim found in one file.
28	The received date of VCR claim cannot exceed 18 months from “Date of Service”	Received month for the VCR claim should be within 18 months of the month of “Date of Service”	Claim received after 18 months.	INFO	The original received date will not be preserved.	The received date of VCR claim cannot exceed 18 months from “Date of Service”

6.14 TABLE N – 835 CODE DEFINITIONS

CLAIM STATUS CODE - SEE 835, PG. 90-91 - THIS MUST BE PLACED AT THE CLAIM LEVEL.	
Code	**Description**
4	Denied
13	Suspended
25	Predetermination Pricing Only - No Payment
CLAIM ADJUSTMENT GROUP CODE SEE 835, PG. 97 OR 150	
Code	Description
CO	Contractual Obligations
OA	Other Adjustments
PI	Payer Initiated Reductions
PR	Patient Responsibility
HEALTH CARE CLAIM ADJUSTMENT REASON CODES - THESE CODES CAN BE USED MULTIPLE TIMES UNDER A GIVEN CLAIM ADJUSTMENT GROUP CODE	
Code	**Description**
11	Diagnosis inconsistent with procedure
16	Claim lacks info for adjudication. See Remarks Codes.
17	Unidentified Error
18	Duplicate claim/service
26	Expenses incurred prior to coverage
29	The time limit for filing has expired
31	Claim denied as patient cannot be identified as our insured
42	Charges exceed our fee schedule or maximum allowable amount
110	Billing date predates service date
119	Benefit maximum for this time period has been reached.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
A1	Claim Denied charges
A2	No error, but it reduces the total amount billed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
REMITTANCE ADVICE REMARK CODES - USED IN REMITTANCE ADVICE TO RELAY INFORMATIONAL MESSAGES THAT CANNOT BE EXPRESSED WITH A CLAIMS ADJUSTMENT REASON CODE.	
Code	**Description**
M16	Please see the letter of (date) for further information. (The letter number and date must be supplied).
M51	Missing/incomplete/invalid procedure code(s) and/or rates.
M53	Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.
M54	Did not complete or enter the correct charges for services rendered.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.

M81	Patient's diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity
MA21	SSA records indicate mismatch with name and sex
MA31	Incomplete/invalid beginning and ending dates of the period billed
MA39	Incomplete/invalid patient's sex
MA40	Incomplete/invalid admission date
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number
MA63	Incomplete/invalid principle diagnosis code
MA66	Incomplete/invalid principle procedure code and/or date
MA92	Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information
MA130	Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount. This Remark Code will be deactivated October 1, 2007.
N20	Service not payable with other service rendered on the same date.
N50	Missing/incomplete/invalid discharge information.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N59	Please refer to your provider manual for additional program and provider information.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month

REMITTANCE ADVICE REMARK CODES - USED IN REMITTANCE ADVICE TO RELAY INFORMATIONAL MESSAGES THAT CANNOT BE EXPRESSED WITH A CLAIMS ADJUSTMENT REASON CODE.

Code	Description
M16	Please see the letter of (date) for further information. (The letter number and date must be supplied).
M51	Missing/incomplete/invalid procedure code(s) and/or rates.
M53	Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.
M54	Did not complete or enter the correct charges for services rendered.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	Patient's diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity
MA21	SSA records indicate mismatch with name and sex
MA31	Incomplete/invalid beginning and ending dates of the period billed
MA39	Incomplete/invalid patient's sex
MA40	Incomplete/invalid admission date
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number
MA63	Incomplete/invalid principle diagnosis code

MA66	Incomplete/invalid principle procedure code and/or date
MA92	Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information
MA130	Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
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N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N59	Please refer to your provider manual for additional program and provider information.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month

6.15 TABLE O – COUNTY CODES

COUNTY	CODE	COUNTY	CODE
Alpine	02	Plumas	32
Amador	03	Riverside	33
Butte	04	Sacramento	34
Calaveras	05	San Benito	35
Colusa	06	San Bernardino	36
Contra Costa	07	San Diego	37
Del Norte	08	San Francisco	38
El Dorado	09	San Joaquin	39
Fresno	10	San Luis Obispo	40
Glenn	11	San Mateo	41
Humboldt	12	Santa Barbara	42
Imperial	13	Santa Clara	43
Inyo	14	Santa Cruz	44
Kern	15	Shasta	45
Kings	16	Sierra	46
Lake	17	Siskiyou	47
Lassen	18	Solano	48
Los Angeles	19	Sonoma	49
Madera	20	Stanislaus	50
Marin	21	Sutter	51
Mariposa	22	Tehama	52
Mendocino	23	Trinity	53
Merced	24	Tulare	54
Modoc	25	Tuolumne	55
Mono	26	Ventura	56
Monterey	27	Yolo	57
Napa	28	Yuba	58
Nevada	29	Sutter-Yuba	63
Orange	30	Berkeley City	65
Placer	31	Tri-City MH	66